UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON
AT TACOMA

DREW MACEWEN, ANDREW BARKIS, CHRIS CORRY, BRANDON VICK, KELLY CHAMBERS, MICHAEL MCKEE, FRAN WILLS, BRUCE RUSSELL, PHIL FORTUNATO, DAVE MCMULLAN, AND ISAAC VELLEKAMP,

Plaintiffs,

v.

JAY INSLEE, in my official capacity as the Governor of Washington,

Defendant.

No. 3:20-cv-05423

DECLARATION OF JOEL ARD IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

I, Joel Ard, make the following declaration under penalty of perjury:

1. I am counsel to Plaintiffs in the above-entitled action and have personal knowledge of the facts stated herein.
2. Attached hereto as Exhibit A is a true and correct copy of the June 5, 2020 Chelan-Douglas Health District Application For Movement Beyond Phase 1, the cover page and pp 22-23 with age of nine decedents.
3. Attached hereto as Exhibit B is a true and correct copy of "Skagit Valley Choral History" printed from https://www.skagitvalleychorale.org/chorale-history on June 18, 2020.

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4. Attached hereto as Exhibit C is a true and correct copy of CDC Morbidity and Mortality Weekly Report of May 12, 2020, "High SARS-CoV-2 Attack Rate Following Exposure at a Choir Practice — Skagit County, Washington, March 2020."
5. Attached hereto as Exhibit D is a true and correct copy of Seattle Times Obituary of Carol Rae Woodmansee.
6. Attached hereto as Exhibit E is a true and correct copy of the complete transcript of the State's deposition of Dr. Malcolm Butler.
7. Attached hereto as Exhibit F is a true and correct copy of Governor Inslee's May 30, 2020 statement on George Floyd protests.
8. Attached hereto as Exhibit G is a true and correct copy of CDC Morbidity and Mortality Weekly Report of June 15, 2020, "Coronavirus Disease 2019 Case Surveillance — United States, January 22–May 30, 2020."

SIGNED June 19, 2020, at Bainbridge Island, Washington.

BY: _____
JOEL B. ARD

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Ex. A

CHELAN-DOUGLAS HEALTH DISTRICT
APPLICATION FOR MOVEMENT BEYOND PHASE 1

Submitted Friday, June 5, 2020

Contact Tracers, we translate everything on our website and all other COVID-19 messaging including social media into Spanish. We have billboards in Spanish and Radio PSA's. We have distributed information at Spanish speaking grocery stores, provided Spanish radio interviews, provided training and education to Spanish speaking groups on proper hand washing and social distancing. We use CDC, DOH, Mexican Consulate and CDHD educational materials. We collaborate with Columbia Valley Community Health and our Community Health Workers to provide COVID-19 education in agricultural settings (orchards, camps, etc.) as well as at local grocery stores and through churches. One of our Board of Health members who is also a Chelan County Commissioner has personally visited almost all of the fruit packing warehouses in the area and have observed their efforts to contain this disease and protect ag workers. CDHD is aware that L&I has been very proactive and has imposed strict guidelines, and CDHD has tracked L&I's efforts to enforce them. Our plan also includes more of the above mentioned (radio, billboards, printed materials) and social media in Spanish. We have recruited and trained a group of 15 Latina community health workers to do on-the-street and in-the-church community education on COVID. In spite of these extensive efforts we are continuing to look for ways to enhance the effectiveness of our messaging to the Hispanic community, and have formed an advisory group of community leaders to help direct our efforts. In just the past few days we have received many letters of concern from an organized group of citizens concerned about this issue – organized in the sense that the letters are nearly identical – and are reaching out to them to welcome them into our efforts and benefit from their help and advice.

Additional information recently received regarding farmworker outreach and the concerns of the Latino community will be submitted within the next 3 days, which we believe will be helpful in making a considered decision about this proposal.

11. **Additional Information**

We believe that additional information is needed to evaluate the approach to reopening proposed in this application.

Morbidity and Mortality – It is notable that in spite of our relatively high incidence rates we are experiencing relatively low COVID-19 morbidity, mortality and hospital utilization. Although we have had a total of 437 cases, there have been 9 deaths, for a case fatality rate of 2%. During the month of May, when we confirmed 231 cases and saw two deaths, the case fatality rate was 0.87%. Asymptomatic cases make up 31% of our lab confirmed cases. COVID hospital utilization during the month of May has been low in spite of our relatively high population case rate, especially in recent weeks, as the chart on the following page shows. We are not sanguine about the potential of COVID-19 to produce much more severe results, but our health care system is not currently stressed in spite of having had nearly 450 cases so far.

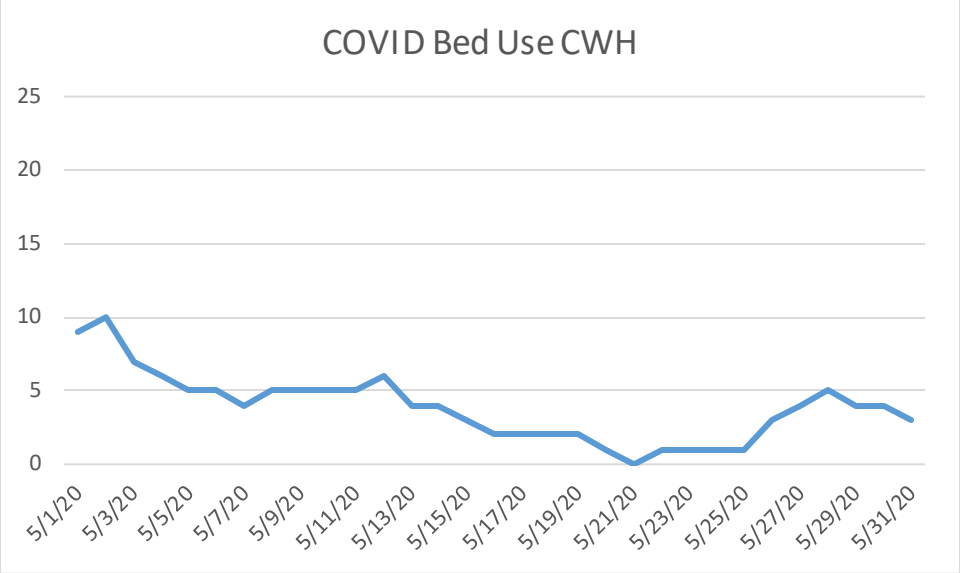
Deaths to Date:

sex	age	dx date		date of death
M	91	3/23/2020	Wenatchee	3/23/2020
F	84	3/26/2020	Wenatchee	3/28/2020
M	92	3/29/2020	Wenatchee	4/8/2020
M	84	3/23/2020	Wenatchee	4/9/2020
F	93	4/6/2020	Wenatchee	4/9/2020
M	91	3/23/2020	E. Wenatchee	4/12/2020

F	68	5/3/2020	Bridgeport	4/26/2020
M	58	5/5/2020	Wenatchee	5/9/2020
F	79	5/1/2020	E. Wenatchee	5/12/2020

CDHD and its health care partners will actively monitor the disease burden in the two counties and, in collaboration with the health care and business sectors, remain ready to reverse proposed reopening measures as needed to respond to significant surges in COVID-19 activity, until the burden of disease again decreases. Our efforts to monitor the course of the epidemic will include the testing of convenience samples (such as the testing ongoing at Confluence of all patients scheduled for procedures), along with others to be determined as testing capacity grows in a reliable manner. The point is not that these samples represent the entire community, but that their fluctuations are likely to reflect trends in the local epidemic.

We are also working to implement a statistically valid prevalence study, but so far this effort has been hampered by the high level of hostility among vocal members of the public. Although these people are a minority, health workers now fear going out into the community to offer testing as part of a random sample. We are working to develop alternative strategies capable of producing a representative sample and hope to collaborate with statewide efforts to develop better estimates of COVID-19 prevalence.



Because of low COVID hospital utilization in recent weeks, CWH has been able to accept overflow patients in its ICU to assist facilities in Yakima.

A Proactive Business Community Committed to COVID-19 Prevention The business community in our counties has demonstrated a remarkable level of commitment to safe reopening. The Wenatchee Valley Chamber of Commerce joined with the Chambers of Commerce from other cities in the area to form a Recovery Council for the express purpose of supporting the safe and responsible reopening of local businesses. The Council developed a Reopening Toolkit, drawing on guidance rom DOH, CDC and other reliable sources, and has established an active partnership with CDHD to work with businesses on reopening plans. This is not a business community wanting to undermine COVID-19 prevention

Ex. B

Skagit Valley CHORALE

Dr. Adam Burdick - Conductor

Celebrating Our 36th Season

CHORALE HISTORY

The Skagit Valley Chorale was founded in 1984 by Joan Penney with the support of the Skagit Valley College Foundation and has grown from its original 30 members to over 120 men and women dedicated to performing quality choral music.

Two annual concerts are performed in Mount Vernon at McIntyre Hall, which is considered one of the premier performing arts venues in the state of Washington. The "Heralding Christmas" concert is presented shortly after Thanksgiving and features classical and contemporary choral works along with a variety of seasonal favorites. The "Celebrating in Song" concert, presented in the spring, features classical choral works as well as a variety of choral music by contemporary composers representing the diversity of world traditions and cultures.

Membership in the Chorale is open on a non-audition basis to anyone wishing to express their singing talent and challenge their vocal skills. Placement within the Chorale is determined by a voice range evaluation. Current membership includes singers from Skagit, Whatcom, Island and Snohomish counties.

Rehearsals are held at the Mount Vernon Presbyterian Church on Tuesday evenings and one monthly Saturday morning.

Since its inception, the Chorale has been privileged to be under the direction of four talented and dedicated Artistic Directors / Conductors.

During the leadership of founder Joan Penney (1984-1993), the Chorale traveled to Carnegie Hall to perform Mozart's Requim and then the Nina Festival at the Kennedy Center in Washington, D.C.

Under Jim Matthews (1994-2003), a Chorale member and retired award-winning high school choral and instrumental music teacher, the membership grew to its current level.

After Janet Skones Hitt became Conductor (2004-2014), the Chorale participated in McIntyre Hall's 2005 opening season; performed at the 2006 Mozart Choral Festival in Salzburg and Vienna to celebrate the 250th anniversary of the composer's birth; and performed at the Vatican's St. Peter's Basilica as well as other historic Italian cathedrals during the 2011 Rome International Choral Festival.

In 2014, Dr. Adam Burdick became the Chorale's current Artistic Director and Conductor bringing with him a wealth of experience. To learn more about Dr. Burdick, read his bio.

Proud member of the greater seattle CHORAL consortium

Site photos by John Yaeger - Yaeger, Inc.
Banner photos by Colzie Bettinger

like us on facebook

Skagit Valley Chorale
P.O. Box 2976, Mount Vernon, WA

Become a Chorale Supporter

Ex. C

Morbidity and Mortality Weekly Report

High SARS-CoV-2 Attack Rate Following Exposure at a Choir Practice — Skagit County, Washington, March 2020

Lea Hamner, MPH[1]; Polly Dubbel, MPH[1]; Ian Capron[1]; Andy Ross, MPH[1]; Amber Jordan, MPH[1]; Jaxon Lee, MPH[1]; Joanne Lynn[1]; Amelia Ball[1]; Simranjit Narwal, MSc[1]; Sam Russell[1]; Dale Patrick[1]; Howard Leibrand, MD[1]

On May 12, 2020, this report was posted as an MMWR *Early Release on the* MMWR *website (https://www.cdc.gov/mmwr).*

On March 17, 2020, a member of a Skagit County, Washington, choir informed Skagit County Public Health (SCPH) that several members of the 122-member choir had become ill. Three persons, two from Skagit County and one from another area, had test results positive for SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19). Another 25 persons had compatible symptoms. SCPH obtained the choir's member list and began an investigation on March 18. Among 61 persons who attended a March 10 choir practice at which one person was known to be symptomatic, 53 cases were identified, including 33 confirmed and 20 probable cases (secondary attack rates of 53.3% among confirmed cases and 86.7% among all cases). Three of the 53 persons who became ill were hospitalized (5.7%), and two died (3.7%). The 2.5-hour singing practice provided several opportunities for droplet and fomite transmission, including members sitting close to one another, sharing snacks, and stacking chairs at the end of the practice. The act of singing, itself, might have contributed to transmission through emission of aerosols, which is affected by loudness of vocalization (*1*). Certain persons, known as superemitters, who release more aerosol particles during speech than do their peers, might have contributed to this and previously reported COVID-19 superspreading events (*2*–*5*). These data demonstrate the high transmissibility of SARS-CoV-2 and the possibility of superemitters contributing to broad transmission in certain unique activities and circumstances. It is recommended that persons avoid face-to-face contact with others, not gather in groups, avoid crowded places, maintain physical distancing of at least 6 feet to reduce transmission, and wear cloth face coverings in public settings where other social distancing measures are difficult to maintain.

Investigation and Findings

The choir, which included 122 members, met for a 2.5-hour practice every Tuesday evening through March 10. On March 15, the choir director e-mailed the group members to inform them that on March 11 or 12 at least six members had developed fever and that two members had been tested for SARS-CoV-2 and were awaiting results. On March 16, test results for three members were positive for SARS-CoV-2 and were reported to two respective local health jurisdictions, without indication of a common source of exposure. On March 17, the choir director sent a second e-mail stating that 24 members reported that they had developed influenza-like symptoms since March 11, and at least one had received test results positive for SARS-CoV-2. The email emphasized the importance of social distancing and awareness of symptoms suggestive of COVID-19. These two emails led many members to self-isolate or quarantine before a delegated member of the choir notified SCPH on March 17.

All 122 members were interviewed by telephone either during initial investigation of the cluster (March 18–20; 115 members) or a follow-up interview (April 7–10; 117); most persons participated in both interviews. Interviews focused on attendance at practices on March 3 and March 10, as well as attendance at any other events with members during March, other potential exposures, and symptoms of COVID-19. SCPH used Council of State and Territorial Epidemiologists case definitions to classify confirmed and probable cases of COVID-19 (*6*). Persons who did not have symptoms at the initial interview were instructed to quarantine for 14 days from the last practice they had attended. The odds of becoming ill after attending each practice were computed to ascertain the likelihood of a point-source exposure event.

No choir member reported having had symptoms at the March 3 practice. One person at the March 10 practice had cold-like symptoms beginning March 7. This person, who had also attended the March 3 practice, had a positive laboratory result for SARS-CoV-2 by reverse transcription–polymerase chain reaction (RT-PCR) testing.

In total, 78 members attended the March 3 practice, and 61 attended the March 10 practice (Table 1). Overall, 51 (65.4%) of the March 3 practice attendees became ill; all but one of these persons also attended the March 10 practice. Among 60 attendees at the March 10 practice (excluding the patient who became ill March 7, who also attended), 52 (86.7%) choir members subsequently became ill. Some members exclusively attended one practice; among 21 members who only attended March 3, one became ill and was not tested (4.8%), and among three members who only attended March 10, two became ill (66.7%), with one COVID-19 case being laboratory-confirmed.

Summary

What is already known about this topic?

Superspreading events involving SARS-CoV-2, the virus that causes COVID-19, have been reported.

What is added by this report?

Following a 2.5-hour choir practice attended by 61 persons, including a symptomatic index patient, 32 confirmed and 20 probable secondary COVID-19 cases occurred (attack rate = 53.3% to 86.7%); three patients were hospitalized, and two died. Transmission was likely facilitated by close proximity (within 6 feet) during practice and augmented by the act of singing.

What are the implications for public health practice?

The potential for superspreader events underscores the importance of physical distancing, including avoiding gathering in large groups, to control spread of COVID-19. Enhancing community awareness can encourage symptomatic persons and contacts of ill persons to isolate or self-quarantine to prevent ongoing transmission.

Because illness onset for 49 (92.5%) patients began during March 11–15 (Figure), a point-source exposure event seemed likely. The median interval from the March 3 practice to symptom onset was 10 days (range = 4–19 days), and from the March 10 practice to symptom onset was 3 days (range = 1–12 days). The odds of becoming ill after the March 3 practice were 17.0 times higher for practice attendees than for those who did not attend (95% confidence interval [CI] = 5.5–52.8), and after the March 10 practice, the odds were 125.7 times greater (95% CI = 31.7–498.9). The clustering of symptom onsets, odds of becoming ill according to practice attendance, and known presence of a symptomatic contagious case at the March 10 practice strongly suggest that date as the more likely point-source exposure event. Therefore, that practice was the focus of the rest of the investigation. Probable cases were defined as persons who attended the March 10 practice and developed clinically compatible COVID-19 symptoms, as defined by Council of State and Territorial Epidemiologists (*6*). The choir member who was ill beginning March 7 was considered the index patient.

The March 10 choir rehearsal lasted from 6:30 to 9:00 p.m. Several members arrived early to set up chairs in a large multipurpose room. Chairs were arranged in six rows of 20 chairs each, spaced 6–10 inches apart with a center aisle dividing left and right stages. Most choir members sat in their usual rehearsal seats. Sixty-one of the 122 members attended that evening, leaving some members sitting next to empty seats. Attendees practiced together for 40 minutes, then split into two smaller groups for an additional 50-minute practice, with one of the groups moving to a smaller room. At that time, members in the larger room moved to seats next to one another, and members in the smaller room sat next to one another on benches. Attendees then had a 15-minute break, during which cookies and oranges were available at the back of the large room, although many members reported not eating the snacks. The group then reconvened for a final 45-minute session in their original seats. At the end of practice, each member returned their own chair, and in the process congregated around the chair racks. Most attendees left the practice immediately after it concluded. No one reported physical contact between attendees. SCPH assembled a seating chart of the all-choir portion of the March 10 practice (not reported here because of concerns about patient privacy).

Among the 61 choir members who attended the March 10 practice, the median age was 69 years (range = 31–83 years); 84% were women. Median age of those who became ill was 69 years, and 85% of cases occurred in women. Excluding the laboratory-confirmed index patient, 52 (86.7%) of 60 attendees became ill; 32 (61.5%) of these cases were confirmed by RT-PCR testing and 20 (38.5%) persons were considered to have probable infections. These figures correspond to secondary attack rates of 53.3% and 86.7% among confirmed and all cases, respectively. Attendees developed symptoms 1 to 12 days after the practice (median = 3 days). The first SARS-CoV-2 test was performed on March 13. The last person was tested on March 26.

Three of the 53 patients were hospitalized (5.7%), including two who died (3.8%). The mean interval from illness onset to hospitalization was 12 days. The intervals from onset to death were 14 and 15 days for the two patients who died.

SCPH collected information about patient signs and symptoms from patient interviews and hospital records (Table 2). Among persons with confirmed infections, the most common signs and symptoms reported at illness onset and at any time during the course of illness were cough (54.5% and 90.9%, respectively), fever (45.5%, 75.8%), myalgia (27.3%, 75.0%), and headache (21.2%, 60.6%). Several patients later developed gastrointestinal symptoms, including diarrhea (18.8%), nausea (9.4%), and abdominal cramps or pain (6.3%). One person experienced only loss of smell and taste. The most severe complications reported were viral pneumonia (18.2%) and severe hypoxemic respiratory failure (9.1%).

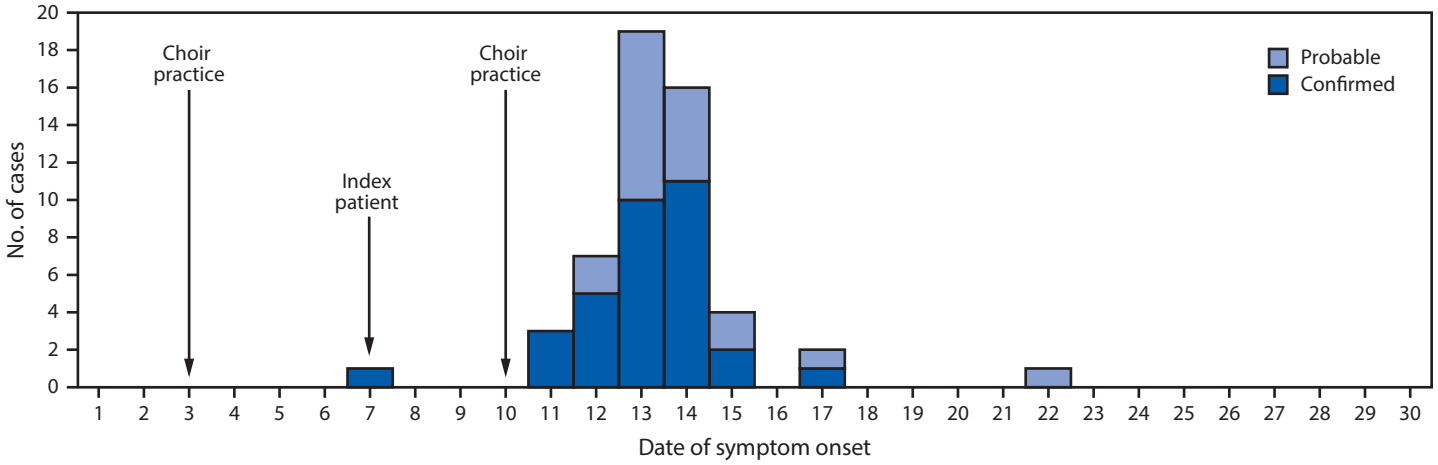
Among the recognized risk factors for severe illness, the most common was age, with 75.5% of patients aged ≥65 years. Most patients (67.9%) did not report any underlying medical conditions, 9.4% had one underlying medical condition, and 22.6% had two or more underlying medical conditions. All three hospitalized patients had two or more underlying medical conditions.

TABLE 1. Number of choir members with and without COVID-19–compatible symptoms (N = 122)* and members' choir practice attendance† — Skagit County, Washington, March 3 and 10, 2020

	No. (row %)					
	March 3 practice			March 10 practice		
Attendance	Total	Symptomatic	Asymptomatic	Total	Symptomatic	Asymptomatic
Attended	78	51 (65.4)	27 (34.6)	61	53§ (86.9)	8 (13.1)
Did not attend	40	4 (10.0)	36 (90.0)	61	3 (4.9)	58 (95.1)
Attendance information missing	4	1 (25.0)	3 (75.0)	0	0 (—)	0 (—)
Attended only one practice	21	1 (4.8)	20 (95.2)	3	2 (66.7)	1 (33.3)

Abbreviation: COVID-19 = coronavirus disease 2019.
* No choir members were symptomatic at the March 3 practice.
† Thirty-seven choir members attended neither practice; two developed symptoms, and 35 remained asymptomatic.
§ Includes index patient; if the index patient excluded, 52 secondary cases occurred among the other 60 attendees (attack rate = 86.7%).

FIGURE. Confirmed* and probable† cases of COVID-19 associated with two choir practices, by date of symptom onset (N = 53) — Skagit County, Washington, March 2020



Abbreviation: COVID-19 = coronavirus disease 2019.
* Positive reverse transcription–polymerase chain reaction test result.
† Attendance at the March 10 practice and clinically compatible symptoms as defined by the Council of State and Territorial Epidemiologists, Interim-20-ID-01: Standardized surveillance case definition and national notification for 2019 novel coronavirus disease (COVID-19). https://cdn.ymaws.com/www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdf.

Public Health Response

SCPH provided March 10 practice attendees with isolation and quarantine instructions by telephone, email, and postal mail. Contacts of patients were traced and notified of isolation and quarantine guidelines. At initial contact, 15 attendees were quarantined, five of whom developed symptoms during quarantine and notified SCPH.

Before detection of this cluster on March 17, Skagit County had reported seven confirmed COVID-19 cases (5.4 cases per 100,000 population). At the time, SCPH informed residents that likely more community transmission had occurred than indicated by the low case counts.* On March 21, SCPH issued a press release to describe the outbreak and raise awareness about community transmission.† The press release emphasized the highly contagious nature of COVID-19 and the importance of following social distancing guidelines to control the spread of the virus.

Discussion

Multiple reports have documented events involving superspreading of COVID-19 (*2*–*5*); however, few have documented a community-based point-source exposure (*5*). This cluster of 52 secondary cases of COVID-19 presents a unique opportunity for understanding SARS-CoV-2 transmission following a likely point-source exposure event. Persons infected with SARS-CoV-2 are most infectious from 2 days before through 7 days after symptom onset (*7*). The index patient developed symptoms on March 7, which could have placed the patient within this infectious period during the March 10 practice. Choir members who developed symptoms on March 11 (three) and March 12 (seven) attended both the March 3

* Skagit County, updated social distancing information. https://skagitcounty.net/departments/home/press/031620.htm.
† Skagit County, public health investigating cluster of related COVID-19 cases. https://skagitcounty.net/departments/home/press/032120.htm.

TABLE 2. Signs and symptoms reported at the onset of COVID-19 illness and during the course of illness among persons infected at a choir practice (N = 53)* — Skagit County, Washington, March 2020

Sign or symptom	No. (%)		no./No. (%)	
	Reported at onset of illness		Reported during course of illness	
	All cases (N = 53)	Confirmed cases (N = 33)	All cases (N = 53)	Confirmed cases (N = 33)
Cough	27 (50.9)	18 (54.5)	47/53 (88.7)	30/33 (90.9)
Fever	28 (52.8)	15 (45.5)	36/53 (67.9)	25/33 (75.8)
Myalgia	13 (24.5)	9 (27.3)	34/52 (65.4)	24/32 (75.0)
Headache	10 (18.9)	7 (21.2)	32/53 (60.4)	20/33 (60.6)
Chills or rigors	7 (13.2)	6 (18.2)	23/51 (45.1)	16/31 (51.6)
Congestion	4 (7.5)	2 (6.1)	25/52 (48.1)	15/32 (46.9)
Pharyngitis	2 (3.8)	2 (6.1)	12/52 (23.1)	8/32 (25.0)
Lethargy	4 (7.5)	2 (6.1)	5/52 (9.6)	3/32 (9.4)
Fatigue	3 (5.7)	1 (3.0)	24/52 (46.2)	15/32 (46.9)
Aguesia (loss of taste)	1 (1.9)	1 (3.0)	11/48 (22.9)	5/28 (17.9)
Anosmia (loss of smell)	1 (1.9)	1 (3.0)	10/48 (20.8)	5/28 (17.9)
Chest congestion or tightness	1 (1.9)	1 (3.0)	5/52 (9.6)	4/32 (12.5)
Weakness	1 (1.9)	1 (3.0)	3/52 (5.8)	2/32 (6.3)
Eye ache	1 (1.9)	1 (3.0)	1/52 (1.9)	1/32 (3.1)
Dyspnea	0 (—)	0 (—)	8/51 (15.7)	8/31 (25.8)
Diarrhea	0 (—)	0 (—)	8/52 (15.4)	6/32 (18.8)
Pneumonia	0 (—)	0 (—)	6/53 (11.3)	6/33 (18.2)
Nausea	0 (—)	0 (—)	3/52 (5.8)	3/32 (9.4)
Acute hypoxemic respiratory failure	0 (—)	0 (—)	3/53 (5.7)	3/33 (9.1)
Abdominal pain or cramps	0 (—)	0 (—)	2/52 (3.8)	2/32 (6.3)
Malaise	1 (1.9)	0 (—)	1/52 (1.9)	0/32 (—)
Anorexia	0 (—)	0 (—)	1/52 (1.9)	0/32 (—)
Vomiting	0 (—)	0 (—)	0/52 (—)	0/32 (—)

Abbreviation: COVID-19 = coronavirus disease 19.
* Including the index patient.

and March 10 practices and thus could have been infected earlier and might have been infectious in the 2 days preceding symptom onset (i.e., as early as March 9). The attack rate in this group (53.3% and 86.7% among confirmed cases and all cases, respectively) was higher than that seen in other clusters, and the March 10 practice could be considered a superspreading event (*3*,*4*). The median incubation period of COVID-19 is estimated to be 5.1 days (*8*). The median interval from exposure during the March 10 practice to onset of illness was 3 days, indicating a more rapid onset.

Choir practice attendees had multiple opportunities for droplet transmission from close contact or fomite transmission (*9*), and the act of singing itself might have contributed to SARS-CoV-2 transmission. Aerosol emission during speech has been correlated with loudness of vocalization, and certain persons, who release an order of magnitude more particles than their peers, have been referred to as superemitters and have been hypothesized to contribute to superspeading events (*1*). Members had an intense and prolonged exposure, singing while sitting 6–10 inches from one another, possibly emitting aerosols.

The findings in this report are subject to at least two limitations. First, the seating chart was not reported because of concerns about patient privacy. However, with attack rates of 53.3% and 86.7% among confirmed and all cases, respectively, and one hour of the practice occurring outside of the seating arrangement, the seating chart does not add substantive additional information. Second, the 19 choir members classified as having probable cases did not seek testing to confirm their illness. One person classified as having probable COVID-19 did seek testing 10 days after symptom onset and received a negative test result. It is possible that persons designated as having probable cases had another illness.

This outbreak of COVID-19 with a high secondary attack rate indicates that SARS-CoV-2 might be highly transmissible in certain settings, including group singing events. This underscores the importance of physical distancing, including maintaining at least 6 feet between persons, avoiding group gatherings and crowded places, and wearing cloth face coverings in public settings where other social distancing measures are difficult to maintain during this pandemic. The choir mitigated further spread by quickly communicating to its members and notifying SCPH of a cluster of cases on March 18. When first contacted by SCPH during March 18–20, nearly all persons who attended the practice reported they were already self-isolating or quarantining. Current CDC recommendations, including maintaining physical distancing of at least 6 feet and wearing cloth face coverings if this is not feasible, washing hands often, covering coughs and sneezes, staying home when ill, and frequently cleaning and disinfecting

high-touch surfaces, remain critical to reducing transmission. Additional information is available at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html.

Acknowledgments

Patients described in this report; health care personnel who cared for them; Skagit County Public Health staff members and leaders, particularly the Communicable Disease investigators; Washington State Department of Health.

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[1]Skagit County Public Health, Mount Vernon, Washington.

All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. All authors report receipt of funding through Public Health Emergency Preparedness grant from the Washington State Department of Health during the conduct of the study. No other potential conflicts of interest were disclosed.

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Ex. D

Obituaries
The Seattle Times

Carole Rae Woodmansee, whose life centered on family, faith and music, dies at 81 of coronavirus complications

April 25, 2020 at 5:00 pm | *Updated April 25, 2020 at 6:07 pm*

Carole Rae Woodmansee, whose life was filled with family, church, service and song, died March 27, her 81st birthday, from complications of COVID-19. (Courtesy of Wendy Jensen)

By Moira Macdonald
Seattle Times arts critic

Editor's note: We often hear about the impact of the coronavirus pandemic in numbers of cases and deaths. But each data point represents a human life whose loss is felt by countless other people. We are chronicling some of them in an obituary series called Lives Remembered. If someone special to you has died of COVID-19, please tell us about them by emailing newstips@seattletimes.com with the subject line "Lives Remembered," or by filling out the form at the bottom of this page.

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Throughout her life, Carole Rae Woodmansee was known for putting others first. In her final days, speaking to her children by telephone from her Mount Vernon hospital

bed, she reassured them, telling them she wasn't afraid and that she was praying for them all. She quoted her favorite hymn, "Blessed Assurance": "This is my story, this is my song / Praising my Savior, all the day long."

"That so was my mom," said her son, Joe Woodmansee. "That's who she was."

A woman for whom family, faith and music were the touchstones of her life, Mrs. Woodmansee died on the morning of March 27 — her 81st birthday — from complications of COVID-19. She contracted the virus, her family believes, from a March 10 rehearsal of the Skagit Valley Chorale, after which several dozen singers became ill. She had been a longtime member of the group.

"I think singing was life, music was life to her," said her youngest daughter, Wendy Jensen. "It's what soothed her, it's what made her happy, it encouraged her."

Her son concurred, saying that his mother believed that music "could draw people closer to God, and help them through hard times."

An alto whose voice harmonized beautifully with others', Mrs. Woodmansee began singing in a trio with friends in high school. It was the first note in a life filled with music: playing and teaching piano, singing, leading choirs (at one point, while living in California, she directed four different choirs at her church), directing children's music camps, and other forms of music ministry. "She loved every aspect of it," said Jensen. "In fact, the last Bible study that she taught was on hymns, the old hymns."

Carole Rae Dean was born in Centralia, and married her high school sweetheart, Elmo James (Jim) Woodmansee, in 1957. The couple, who settled in Mount Vernon in 1977, raised an ever-growing family: four children, 16 grandchildren and 25 great-grandchildren. She "absolutely glowed" around her grandchildren, said her son, and loved family gatherings. All of her children and grandchildren live within 30 minutes of each other in the Skagit Valley, and she was able to see them often.

In recent years, she was employed by two of her grandchildren, Paul and Tim Woodmansee, proudly doing part-time office work for their construction company. "For Mom, that was fun to be part of the family business," her son said.

Widowed since 2003, she led a busy life, filled with family, church (she was an active member of Radius Church in Mount Vernon), service and song.

"She was a go-getter," said her daughter Bonnie Dawson. "I wrote a whole post on

Facebook on how her chair is empty now but it doesn't matter because she never really sat in it before."

Dawson remembered, with a smile evident in her voice, that on the evening she was taken to the hospital, her mother took time to empty the dishwasher. "That's the kind of lady she was."

Mrs. Woodmansee enjoyed travel (her children fondly remember recent trips to the Grand Canyon, and to Phoenix for a NASCAR race), gardening and spending time with those she loved. "Basically," said her son, "she was a friend to anyone she ever met."

Her grandson Paul wrote in an email that while the family was heartbroken that she apparently contracted the virus at her beloved chorale, he was nonetheless finding comfort in "imagining my Grandma singing even till the moment she was destined to leave this earth. I believe there is some beauty in doing the things we love to do until the day we pass away."

Moira Macdonald: *mmacdonald@seattletimes.com; on Twitter: @moiraverse. Moira Macdonald is the Seattle Times arts critic.*

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Ex. E

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON

FOR THE COUNTY OF CHELAN

JOSE LUIS CUEVAS, et al, Plaintiffs, vs. JAY INSLEE, in his official capacity as Governor, Defendant.	No. 20-2-00352-04

DEPOSITION OF MALCOM D. BUTLER, M.D.

Taken at the instance of the Defendant

June 8, 2020

10:00 a.m.

139 South Worthen

Wenatchee, Washington

BRIDGES REPORTING & LEGAL VIDEO
Certified Shorthand Reporters
1312 N. Monroe Street
Spokane, Washington 99201
(509) 456-0586 - (800) 358-2345

BE IT REMEMBERED that the deposition of MALCOM D. BUTLER, M.D., was taken in behalf of the Defendant pursuant to the Washington Rules of Civil Procedure before William J. Bridges, Certified Shorthand Reporter for Washington, Idaho and Oregon, on Monday, the 8th day of June, 2020, at the Office of the Attorney General, 139 South Worthen, Suite 100, Wenatchee, Washington, commencing at the hour of 10:00 a.m.

* * *

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Also present: JENNAH WILLIAMS (via Zoom)

* * *

I N D E X:

JOSE LUIS CUEVAS, et al vs. JAY INSLEE

No. 20-2-00352-04

June 8, 2020

T E S T I M O N Y

PRODUCTION REQUESTS:

(None)

E X H I B I T S:

(MALCOM D. BUTLER, M.D., called as a witness by the Defendant, being first duly sworn to tell the truth, the whole truth and nothing but the truth, was examined and testified as follows:)

EXAMINATION

BY MR. JONES:

Q. Good morning, Dr. Butler. I just introduced myself earlier. My name is Zachary Pekelis Jones, P-E-K-E-L-I-S, and I'm an attorney for Governor Inslee in this matter.

Have you ever had your deposition taken before in any court proceeding.

A. Yes.

Q. How many times?

A. Gosh, I don't remember. I think about four in my career.

Q. And what were the nature of those proceedings?

A. Yeah. They've been a long time ago. All of them were medically-related.

One of them was in my role as staff, what's called medical staff officer at Central Washington

Hospital. And the others would have just been --

Q. I'm sorry. I couldn't hear what you just said.

A. Okay. One of them was in my role as a medical staff officer at Central Washington Hospital.

And I believe the others were custody type of hearings and those sort of things.

Q. And were you an expert witness in those hearings?

A. I think in all of them, yes. In no case was I a defendant or a plaintiff. So I must have been an expert in all of them.

Q. Understood. So, just some basic ground rules for this deposition. I understand you have some experience doing this. But just to make it easier on us today.

It is very important that you speak slowly so that the court reporter can take down everything that you say. Particularly if you're ever reading a document, people tend to speak pretty fast. So make sure you slow down consciously whenever you're reading.

Because this deposition is taking place via Zoom today, it's especially important that you wait after every question in case there is an objection or

just to make sure you understand the question, and that I finish asking it.

Otherwise, it could get somewhat confusing and difficult for the court reporter.

If there is an objection, either by Mr. DeWolf who represents the plaintiffs in this matter, or by Mr. Zimmerman, who is the Health District's counsel who's present as well, if you understand the question, you are permitted to answer it.

And it's only if you are instructed by your attorney not to answer the question on the basis of privilege that you should actually not answer the question.

Does that make sense to you?

A. Well, I understand your words. I guess we'll see how it works out in practice.

Q. Fair enough. In other words, unless your attorney says "Don't answer it," answer the question if you understand it.

A. Very good.

Q. Please give full and complete answers. Do you understand the oath that you have taken here today?

A. Yes.

Q. Is there anything about that oath that was

confusing or ambiguous to you?

A. No.

Q. Okay. And if you remember something later, you know, a supplement to an answer you've previously given, feel free to let me know and we can go back to that earlier question, if it occurs to you later or during a break, at any time, if you want to clarify or add to a previous answer, feel free to do so.

Does that make sense?

A. Yes.

Q. And I don't expect this deposition to take very long. Perhaps a few hours. But if for whatever reason you want to break, whether to use the facilities or for some water, please let me know and we can do that.

Okay?

A. Yes.

Q. Are you sick today in any way?

A. No.

Q. Are you under a doctor's care for any illness?

A. No.

Q. Have you taken any drugs, alcohol or prescription medications today?

A. No. Well, actually, Zach, I have asthma.

So I used my asthma inhaler this morning.
Q. Any medications or other substances that might impair or inhibit your ability to understand my questions and answer them truthfully?
A. No.
Q. Okay. Any other reason why you would be unable to understand my questions or answer them truthfully?
A. Not on my part, no.
Q. Okay. And did you receive a subpoena and a deposition notice for today's deposition?
A. Yes.
Q. Okay. I'd like to just begin talking about your educational and professional background briefly.
What are your current professional positions?
A. I'm currently the Chief Medical Officer at Columbia Valley Community Health. I am a physician with expertise in family medicine.
Q. And how long have you been in that position at Columbia Valley Community Health?
A. 27 years.
Q. And are there any other positions that you currently hold professionally?
A. I am currently the health officer for Chelan

and Douglas Counties, local health jurisdiction.
Q. And is that the Chelan-Douglas County Health District?
A. Correct.
Q. So, we may refer to that entity repeatedly today. Just for short, I'm going to refer to it as the Health District.
Does that make sense to you?
A. Yes.
Q. Okay. And how long have you been in that position as health officer with the Health District?
A. Since April 20, 2020.
Q. April 20th, 2020?
A. Correct.
Q. Any other current professional positions that you hold?
A. I sit on various committees, but none, I wouldn't consider them as sort of professional titled positions or anything like that.
I have a faculty appointment at the University of Washington, that sort of thing.
Q. Understood. You mention that you have an expertise in family medicine. Could you just describe the educational credentials that you have received in

the course of that practice?
A. I have a B.A. in philosophy from Cornell University.
Q. Uh-huh.
A. I have a Medical Doctorate from the University of Washington.
I am board certified in family medicine, having completed a three-year family medicine residency at the University of California, Los Angeles.
Q. Any other education or training in the course of your medical degree -- medical experience?
A. I have had continuous additional training throughout my medical career.
Q. Do you have any training specifically in the field of public health?
A. No.
Q. Okay. Other than your experience as the Health Officer with the Chelan-Douglas County Health District, do you have experience in the field of public health?
A. In as much as public health relates to a primary care practice in a rural community, yes.
Q. Have you had a specific position in public health management or administration?
A. No.

Q. Turning to your experience with the Health District, you began relatively recently.
Can you describe the circumstances under which you came to occupy the position as Health Officer with the Health District?
A. I was approached by Barry Kling who manages the Health District. He asked if I would be willing to step up during this pandemic to assist the Health District.
The prior health officer is a retired oral surgeon. And there were concerns about his capacity to actively direct and manage this crisis for the Health District.
Q. And why was that, if you know?
A. Because of his age and time out of practice.
Q. And what was the name of the prior Health Officer?
A. Francis Collins.
Q. And is he still serving in an emeritus capacity for the Health District?
A. Yes.
Q. Could you explain what the hierarchy of the Health District leadership is? For example, to whom do you report and who reports to you?
A. I report to the Board of Health. There is

nobody who reports to me.
Q. And you mentioned Mr. Kling earlier. What is his position with the Health District?
A. He is the director.
Q. Is he also referred to as the administrator?
A. Yes.
Q. And to whom does he report?
A. He reports to the board.
Q. And who reports to him?
A. The rest of the agency. If you expect me, Zach, to have those memorized, I'm sorry, I will let you down.
Q. That's fine. It's safe to say that all other full-time employees report to Mr. Kling?
A. I couldn't say if they were full-time. As far as I'm aware, all other employees through their supervisors report up through and to Mr. Kling.
Q. Understood. And you mentioned the Board of Health. Who, if you know, are the members of the Board of Health? Either you can say their specific names, or generally what their positions are.
A. Well, Jill Thompson is currently the President of the Board. I believe she is the Mayor of Waterville.
Dan Sutton and Marc Straub, Kevin Overbay,

Doug England are all County Commissioners. Two from Douglas County, two from Chelan County.
Ruth Esparza is a local attorney, and I believe on the Wenatchee City Council. And there's a woman named Sharon who I know lives in Leavenworth. I'm not sure what her role or other titles might be.
Q. Is she an elected official, as well?
A. I do not know.
Q. And is there also a Mr. John Sterk who's on the board?
A. I believe so, yes.
Q. Prior to becoming the Health Officer in April of 2020, did you know any of the board members personally?
A. No.
Q. Do you know if any of the board members is an expert or professional in any medical field?
A. I'm not aware that any of them have any medical expertise, no.
Q. So, I guess none is an expert in -- none of them expert or professional in epidemiology?
A. I'm sorry. I don't know what background any of them have in epidemiology.
Q. And do you know whether any of them have a

background in public health?
A. I'm not aware that any of them have any type of public health background or training.
Q. What about Mr. Kling? Did you know Mr. Kling personally before becoming the Health Officer for the Health District?
A. I had interacted with Mr. Kling professionally prior to taking this role. We had no relationship outside of those professional interactions.
Q. What were your professional interactions with Mr. Kling?
A. Well, two years ago Chelan and Douglas Counties had an accountable health organization developed, or an ACH. So we were the North Central Accountable Care Organization through Medicaid. And that brought a lot of local health care leaders together.
The ACH was directed by Senator Parlette. And her team was housed with the Health District.
So, I had interactions with that team frequently, both in my role as Chief Medical Officer of a federally qualified health center.
I was also asked to head the opioid response for the ACH. In that role I worked fairly closely with

certain team members of the ACH. And we had regular meetings. Various members of the Health District were also participating in various roles. It was largely in that way.
As a primary care provider I am mandated to report infectious diseases and other things to the Health District. I have worked with them regularly in that capacity, and in working on contagion throughout the years.
Q. Do you know what Mr. Kling's professional training is in?
A. I do not know specifically. I know that he previously had a role in the Midwest. I'm aware that he has held similar positions in the past. I do not know what his actual academic work has been.
Q. Based on your experience working with him at the Health District and prior, would you describe Mr. Kling as knowledgeable and experienced in the field of public health?
A. Yes.
Q. So, I would like to turn to our first exhibit today, which is tab H.
A. Okay. There are no tabs. How would I find tab H?
MR. JONES: Right here (indicating).

THE WITNESS: Ah. Okay. Tab H. And there's also no --
MR. ZIMMERMAN: Do you have a Bates stamp number?
MR. JONES: Yes. It's 880. 000080.
THE WITNESS: Tab H. Found it.
MR. DE WOLF: Excuse me, Jack. I think you said 080, or 880?
MR. JONES: 000080.
MR. DE WOLF: Number 80?
MR. JONES: Yes. 80.
COURT REPORTER: Do we want to Mark this as Exhibit 1.
MR. JONES: Yes, please.
(Deposition Exhibit Number 1 was marked for identification).

Q. (BY MR. JONES:) So, Exhibit 1, which you have just been handed, is Proclamation 20-25.4 issued by the Governor of Washington, Jay Inslee.
Are you familiar with the Stay Home - Stay Healthy order issued by the Governor?
A. Yes.
Q. I'd like to turn your attention to the first paragraph on page 81, which begins "Whereas, on February 29th, 2020."

Do you see that?
A. Yes.
Q. And please just read along as I read aloud.
"Whereas, on February 29, 2020, I issued Proclamation 20-05, proclaiming a State of Emergency for all counties throughout the state of Washington as a result of the coronavirus disease 2019 (COVID-19) outbreak in the United States and confirmed person-to-person spread of COVID-19 in Washington State."
Do you see where I read that?
A. Yes.
Q. Do you recall on February 29th, 2020, wherein Governor Inslee created a state of emergency due to COVID-19?
A. Yes.
Q. Okay. Now, turning to the second paragraph which begins "Whereas, as a result of the continued worldwide spread," I'd ask that you just read that paragraph to yourself silently, and let me know once you have finished.
Is that all right?
A. Yes.
Q. Thank you.
(Pause in the proceedings).
A. All right.

Q. So, this second paragraph on page 81 refers to Proclamations 20-25 and amendatory proclamations that prohibit "all people in Washington State from leaving their homes except to participate in essential services or essential work and preventing all non-essential businesses in Washington State from conducting business, within the limitations therein."
Is that correct?
A. Yes.
Q. And so I'm going to refer to those proclamations collectively as the Stay Home - Stay Healthy proclamation, or Stay Home - Stay Healthy order.
Does that make sense to you?
A. Yes.
Q. Now, based on your medical training and expertise, did you agree with the Governor's decision to issue the Stay Home - Stay Healthy order?
A. Yes.
Q. Why?
A. It was clear that social distancing was the most effective tool we had to combat the transmission of the virus and the COVID-19 pandemic. It was clear that in order to avoid morbidity and mortality throughout the state the economy had to be sufficiently

curtailed that there was little incentive for individuals to leave their homes.
Q. If you turn your attention to the third Whereas paragraph on page 81, read along silently while I read aloud. "Whereas, the COVID-19 disease, caused by a virus that spreads easily from person to person which may result in serious illness or death and has been classified by the World Health Organization as a worldwide pandemic, has broadly spread throughout Washington State and remains a significant health risk to all of our people, especially members of our most vulnerable populations."
Did I read that correctly?
A. Yes.
Q. Do you agree with this statement by the Governor that COVID-19 remains a significant health risk to all of our people, especially members of our most vulnerable populations?
A. Zach, can I clarify your question?
Q. Sure.
A. You used the word "remains." Are you referring to what is before me here in this document, or are you referring to today as of January -- June 8?
Q. As of today, June 8, would you agree that

COVID-19 remains a significant health risk to all of our people, especially members of our most vulnerable populations?

A. No.

Q. Why not?

A. Our experience is that in the non-medically vulnerable, it is not a significant health risk.

Q. And is that because of a different fatality -- a different fatality rate for non-medically vulnerable, or because of some other reason?

A. In our local experience approximately 30 percent of the people who have tested positive for the virus have had no symptoms at all. It's hard to describe that as a significant health concern for that 30 percent.

I believe locally we have had in the range of 20 to 30 people admitted to the hospital over the course of two or three months.

Again, that doesn't strike me as a significant illness for the vast majority of the people who have tested positive.

Certainly there is a small cohort which I would describe as the medically vulnerable in whom it is extremely dangerous, and I do feel it is appropriate to take the actions necessary to protect that

population from the spread, especially when there is such a large asymptomatic proportion of infectious people.

Q. Do you have an opinion on whether, based on the scientific evidence you have seen, asymptomatic or pre-symptomatic sufferers of COVID-19 can transmit the virus to others?

A. Absolutely.

Q. What is your opinion?

A. What is my opinion on what, Zach?

Q. Sir, my question is whether you have an opinion on --

A. Oh, sorry.

Q. -- that subject.

A. Yes. So, my opinion is that, yes, absolutely the disease is transmitted by asymptomatic individuals.

Q. And as well as pre-symptomatic individuals, right?

A. Pre-symptomatic are also asymptomatic, yes.

Q. So, in light of that, and the risk that it presents to more vulnerable populations, would you agree, kind of slightly changing the wording of this third Whereas paragraph, would you agree that COVID-19 today remains a significant public health risk in

Washington?

A. Yes.

Q. And does it remain a significant public health risk in Chelan County?

A. Yes.

Q. If you will turn to page 82 to the top Whereas paragraph there.

A. (Witness complied).

Q. And would you just read that paragraph at the top to yourself silently, and then I will ask you a question or two about it when you are done.

(Pause in the proceedings).

A. I'm done.

Q. Okay. Would you agree that modelers continue to agree that fully relaxing social distancing measures will result in a sharp increase in the number of COVID-19 cases?

A. Yes.

Q. Okay. Turning to the next page, page 83.

A. (Witness complied).

Q. And this is the top full Whereas paragraph on page 83. Just read along silently as I read aloud.

"Whereas, the worldwide COVID-19 pandemic and its progression in Washington State continue to

threaten the life and health of our people as well as the economy of Washington State, and remain a public disaster affecting life, health, property or the public peace."

Do you see where I read that?

A. Yes.

Q. Do you agree that the worldwide COVID-19 pandemic and its progression in Washington State continue to threaten the life and health of our people as well as the economy of Washington State and remain a public disaster affecting life, health, property or the public peace?

A. Yes.

Q. Setting the document aside now, in your opinion, Dr. Butler, would you say that the state's response to the COVID-19 pandemic has been reasonable in light of the available data and generally accepted public health practices?

A. Can you please explain what you mean by "reasonable"?

Q. Well, is it consistent with the available data and generally accepted public health practices?

A. I believe that the proclamation is consistent and reasonable, based on my knowledge of COVID-19, yes.

Q. So, what steps did the Health District take under your leadership, so, after April 20th, 2020, in response to the COVID-19 pandemic?

A. Zach, are you asking me to recall over 40 hours of work?

Q. Well, just if you could -- I guess I am just asking you to kind of summarize what steps the Health District itself has taken. It doesn't have to be comprehensive, but sort of an overall summary of what the Health District has done in response to the pandemic.

A. Since I --

Q. With the caveat that -- I'm sorry. With the caveat that it's been a lot, and I don't expect you to cover every single step taken in the short time that we have today.

A. Very good. Since I assumed the role of Health Officer I am aware that the Health District has continued a vigorous educational campaign to both the Anglo and Latinx communities.

We have coordinated contact tracing. We have worked closely with the local emergency response teams to coordinate testing and PPE attainment and distribution.

We have worked closely with the healthcare

providers in our jurisdiction to provide mass testings as required.

I have worked closely with the health officers of the surrounding counties to create a unified regional testing strategy, and then to communicate that to the individuals in our jurisdiction who are actually performing testing.

I have worked closely with Mr. Kling to keep the local business community informed with weekly meetings. Same with local elected officials with weekly meetings.

I have worked with the city of Leavenworth on their city response.

A great deal of time has been consumed applying for an initial variance and subsequently a second variance proposal.

I have put out multiple --

Q. Could I stop you there? Those variance proposals were submitted to the Department of Health for the State of Washington?

A. That is correct.

Q. Okay. Have you coordinated or worked closely with the Department of Health during the COVID-19 crisis?

A. I would not describe it as coordinating or

working closely with. I have sought their guidance. I have participated in communications.

Q. And with whom have you communicated with the State Department of Health?

A. Kathy Lofy, Scott Lindquist, John Weisman, Charisa, whose last name isn't coming to me right now, Medical Director of -- Well, maybe it's -- Anyway, Medical Director of Medicaid. And a couple of other folks in various capacities that I don't recall.

Q. Has the Health District shared or received data or information from the State Department of Health?

A. I have personally reviewed the State Department of Health web page and absorbed the information that they present there and update daily.

I have received multiple communications regarding guidance, both from the CDC and the State DOH. Many of them communicated through the State DOH.

I am aware that the state and the local -- our local health jurisdiction are participating in gathering the data local to the state and uploading it to the state database.

Q. And how would you say the resources that the State Department of Health has at its disposal, how

does that compare to what the Health District has?

A. They appear to have three orders of magnitude more resources than we have at our local Health District.

Q. Has the Health District received any resources from the State?

A. The Health District has taken advantage of contact tracing which has been offered through the state.

And then other than the data and the guidance and essentially pushing out guidance, I'm not aware of any other specifics. But again that really has not been part of my role.

Q. Understood. What role did the Board of Health play in the Health District response to the COVID-19 pandemic?

A. Since my time in this position?

Q. Yes.

A. Since my time in this position I have participated in two Board of Health meetings, and probably four emergency meetings.

My impression at the initial April 20 Board of Health meeting was that they were soliciting information in reports, and that they were venting a very strong desire to bring decision-making and control

more local.

At the second, I believe May 18th board meeting there was a similar very strong desire to alter the application of the Governor's proclamation within our jurisdiction.

Outside of -- Oh. There was an interesting maneuver that was undertaken, I believe it was on May 18th, to remove the -- I will back up.

On the Chelan-Douglas Health District website on the landing page there is a link for complaints and concerns regarding the proclamation and how it was implemented.

That was placed there because -- I understand that was placed there because the Health District was being inundated with phone calls and e-mails.

And the hope was that those complaints could be more effectively gathered and then reported back up through the state through a link on the website, on the landing page.

I do recall the Board of Health requested that that link be taken down.

It was unclear to me how that would be helpful or what the rationale was. And I was not in a position to raise that question, as just staffing the

Board of Health.

They also --

Q. Could I interject a question?

A. Sure.

Q. When you say that you weren't sure how that would be helpful, do you mean how the link itself wouldn't be helpful, or how taking it down wouldn't be helpful?

A. Taking it down. It felt to me that that was not helping us collect the concerns of the constituency of the Health District.

Q. Understood. Please continue.

A. I recall also that I believe at the May 18th board meeting a motion was passed to in essence rescind an emergency proclamation that had been taken by the former Health Officer prior to my appointment shortly after the Governor's initial proclamations, which I believe was intended to bring the Health District and its code in line with the Governor's proclamation.

I believe a portion of that gave the Health Officer the authority to fine businesses that were out of compliance.

And I believe the reason the Board of Health wanted it rescinded was because they felt that was unnecessary and didn't feel it was appropriate.

I do recall it was pointed out to the board members at that time that the statutes still empowered the health officer to levy such fines. But the board still took that action.

Outside of those two actions and their directive to create the two variance proposals, I do not recall other direct guidance as regards the management of the pandemic.

Q. Would you describe any tension or conflict or disagreement between the Board of Health and the professional staff of the Health District regarding the response to the COVID-19 pandemic?

A. Will you please repeat the first part of that question?

Q. Sure. My question is whether you perceived any tension or disagreement or conflict between the Board of Health on the one hand and professional staff in the Health District, such as yourself, on the other hand, regarding the District's response to COVID-19?

A. Yes.

Q. Please describe.

A. During my time in this position it has felt that a great deal of energy has been exerted to address the concerns of the members of the Board of Health,

that the Governor's proclamation was unnecessary and destroying the local economy without appropriate observable gains.

I think there was a tension between the medically prepared and epidemiologically prepared individuals who recognized the potential danger of the pandemic, and I felt that we were continuously required to exert our great concern and repeatedly point out the biology and transmissibility of the virus and the rationale for the Governor's proclamation.

Most specifically the elected officials appeared to have an agenda that was very pro-opening of the economy and an effort to minimize the current and future impact of the pandemic within our jurisdiction.

It has been quite frustrating, I believe, certainly for myself and I'm aware for Mr. Kling to be put in a position of trying to utilize an extremely small resource in the local Health District to manage an enormous geographic area with a very diverse population in the midst of the most significant worldwide pandemic in a hundred years, and also to be exerting energies to help the Board of Health members appreciate the gravity from a physiologic and medical perspective, the potential gravity of the

pandemic.

Repeatedly it felt to me that since we had not had multiple deaths, since our hospitals were not overwhelmed, since the vast majority of the individuals in our jurisdiction tolerate the infection without significant morbidity, that therefore the Stay Home - Stay Safe order could be rescinded.

Q. That was the view of the Board of Health members you just described?

A. I felt a great deal of energy was extended against that opinion, and that opinion, yes, was of the Board of Health. Again, not all of them. Largely, the elected members.

Q. You mention that some of the elected officials had an agenda that was very in favor of opening the economy.

Is that right?

A. Correct.

Q. Okay. At any point did you feel that that agenda made it harder for you to do your job to protect the public health in Chelan County and Douglas County?

A. I felt that I was exerting a great deal of energy to counter that -- their position, inasmuch as I already have a full-time job and don't have much

additional effort -- or time, you know, to devote to this.

The fact that a great deal of time was consumed in essence managing the firm opinions of the Board of Health, I felt that it was taking my energy and that time away from other efforts that could have been better expended to protect the public health.

Q. Understood. You referenced earlier the board meeting of May 18th, 2020. I'd like to discuss that for a moment.

So, that meeting on May 18, was that your second board meeting that you attended?

A. Yes. Well, I'm sorry, Zach. That was the second regularly scheduled board meeting that I attended.

Q. And that board meeting on May 18 was held remotely via Zoom?

A. Correct.

Q. Did you appear via Zoom?

A. I was present on audio, not on video.

Q. But you could see some people via video, or you were just on your telephone?

A. No. I was on my computer. Actually, Zach, I remember the first one was only done by telephone.

I believe the second one was done by Zoom.

But there have been so many Zoom meetings, that's my current recollection. But, yes, I was on my computer.

Q. So, could you describe what you remember of that May 18th, 2020 board meeting by Zoom?

A. I believe I already mentioned two motions that I recall from that meeting.

The other thing that was most striking to me was when one of the Douglas County Commissioners, it seemed to me out of nowhere, it was not on the agenda, he asked the Chairwoman if he could present a proposal for me as the Health Officer to sign.

He described it as a document which included eight points, all of which would be easy to verify and should be easy for me to sign.

Q. Just to interject, who was this that was speaking?

A. Marc Straub.

Q. Thank you. Please continue.

A. This took me completely aback. I had no idea what this was about, if this was normal activity. Again, I was new in my role, four weeks. This was only to --

Well, I had had very limited interactions with the board members up until this point.

I will say my initial concern was that they were interested in better understanding my personal view of our capacity to further open the economy and how that would affect our healthcare system.

And it felt awkward, it felt extremely awkward to be asked by elected officials while I was essentially brand-new in my role in a public meeting to sign a document which I had not been -- which had not been brought to my attention prior to the public meeting, had in no way been reviewed with me or my opinions asked about it prior to the public meeting.

So, I felt quite uncomfortable in that moment. I remained silent. Several questions were asked. I do not recall by whom. What was this for? What was it about? Why would the Health Officer need to sign it?

What I recall was Mr. Straub stating that the Douglas County Commissioners wanted this statement to allow them to review all options at their disposal.

Eventually somebody said, "Well, what does Malcolm think about this?"

And I said, "Well" --

I'm sorry. And he read, I believe he read the eight points to the meeting. Several of them did

not make sense to me. Again, it seemed odd to me to bring forward a statement with eight points already laid out.

Again, in my mind I thought he was -- or the perhaps Douglas County Commissioners, or at least his constituency, were interested to know what my position was on this.

I felt I had been fully transparent about my position prior to this meeting, and was happy to discuss my position should I be asked.

But instead they came forth with these eight individual statements.

I told Mr. Straub that I would be happy to review the document, and after review, I would offer my opinion as to whether it was something I could sign.

He sounded satisfied with that. And we proceeded after that.

Again, it was such an unusual situation and directed most specifically at me in my new role in a public forum that that is most of what I recall of that meeting. It was for me the most emotionally ladened portion of that meeting.

Q. Why do you indicate emotionally ladened?

A. Well, as I have described, I was new in my role. I did feel an obligation to the constituency of

our Health District to serve them well, to appear professional and helpful.

I certainly did not want to appear obstreperous or defensive.

I will share, I of course felt defensive.

I feel it would have been more appropriate with a person in my professional capacity who has stepped up in the midst of a pandemic to communicate with me prior to the board meeting about such a document, to let me review it and provide my opinion as to its merits and whether I could sign it.

As I mentioned, that did not happen.

So, I think the emotions I had were surprise and frustration and concern. And "confusion" is the wrong word, but sort of a question of, you know, where on earth is this going and am I about to walk into a mine field?

I will share with you that I have never served before in any type of a public capacity, outside of the Chief of Staff of the local hospital, which is still in a professional capacity. I have rarely been -- rarely spoken at such public forums. Certainly not by Zoom.

I will share I think all of this has been compromised by Zoom. I think if I had been sitting

right next to Marc Straub and he could have pushed the document to me, it would have been a very different type of an interaction.

It certainly felt quite removed, somewhat -- well, very impersonal.

So, those are the emotions I felt.

Q. Knowing what you know now and looking back, do you have the sense that Mr. Straub was trying to take advantage of the newness of your position in asking you to sign that eight point document?

A. I do not believe he had a -- I do not believe it was a pre-meditated understanding of the awkwardness of my being new in my position. I don't believe he thought about that, no.

Q. Okay. I'd like you to turn to Exhibit Q -- well, tab Q, which will be as Exhibit 2.

A. Can you give me a page number?

Q. One moment. It's 200.

A. And you would like me to mark tab Q as Exhibit 2?

Q. Yes, please. And Q will be Exhibit 2.

(Deposition Exhibit Number 2 was marked for identification).

Q. (BY MR. JONES:) So, Dr. Butler, do you have Exhibit 2 in front of you?

A. Yes.

Q. And this is an e-mail from Marc Straub to Lorena Orozco and the Board of Health and others, as well as you, Malcolm Butler, sent on Monday, May 18, 2020, at 3:48 p.m.

Is that right?

A. Yes.

Q. Okay. And in this e-mail Mr. Straub writes, "Good afternoon. Per discussion, I have attached the document that outlines the eight points the Douglas BOCC would request that our Regional Health Officer prepare as a signed statement."

Did I read that correctly?

A. Yes.

Q. And do you recall whether this e-mail was sent during the May 18th board meeting or shortly thereafter?

A. Yes.

Q. All right.

A. I do recall, and, yes, it was sent either during or very close to the end of or shortly thereafter. The meeting started at 3 p.m., I believe. Yeah. This was sent at 3:48.

Q. Understood. And if you will turn to page 202, you will see the attachment to this e-mail. And

it's an eight point document.

If you would take a moment, please, read those eight points silently to yourself and let me know once you have finished.

(Pause in the proceedings).

A. Finished.

Q. Okay. So, is this attached document on page 202 of Exhibit 2, is this consistent with your recollection of what Mr. Straub read aloud during the Zoom meeting?

A. Yes.

Q. Okay. So, at the time of this Zoom meeting were you aware that Mr. Straub was contemplating becoming a plaintiff in a lawsuit against the Governor?

A. No.

Q. Did Mr. Straub say anything about a potential lawsuit or any of the pending lawsuits relating to the Stay Home - Stay Healthy proclamation?

A. He did not mention a lawsuit. He did mention that the Douglas County Board of Commissioners, I believe that's what the BOCC stands for, wanted to use it essentially to evaluate what options they had.

Q. Did he mention what options specifically the

County Commissioners of Douglas County were contemplating?

A. He did not.

Q. Also at this time, May 18, were you aware that board member Dan Sutton was also contemplating becoming a party to a lawsuit to challenge the proclamation?

A. I was not aware of that, no.

Q. Were you aware on May 18th that Ruth Esparza was contemplating becoming a party to a pending lawsuit, challenging the Governor's Stay Home - Stay Healthy order?

A. No.

Q. So, at that meeting none of those three board members said anything about a potential lawsuit or challenging or contesting the Governor's Stay Home - Stay Healthy order?

A. That is correct.

Q. Do you think they should have disclosed that to you?

A. I feel it would have been -- Well, I'm going to back up again. I have ignorance about public meetings.

I am now aware that as a public officer, as soon as I sign a document and return it to an elected

official, it becomes a public document. I was not aware of that on May 18th.

When I look at how this document was composed, in light of the fact that I am now aware of the pending lawsuit, and having read through at least one of the two pending lawsuits, it is clear to me that this document had been created prior to the meeting specifically to support a future lawsuit, as much as the eight points parallel the points which are made in the lawsuit.

That would also explain the unusual presentation of eight individual points, and would also explain why they referred to an influenza -- a document related to an influenza pandemic which to my initial read made absolutely no sense, since this is not an influenza pandemic, but that plan and a rationale regarding how it could potentially at least in a dictionary relate to COVID-19.

So, in retrospect, if our team is to work closely together in the future, yes, it would have been appropriate for them to share with me that this document was being developed to support a lawsuit.

Q. Had they shared that, would you have reacted differently?

A. Again, my understanding that this document

was going to be used by the elected officials in their elected capacities as the Douglas County Board of Commissioners, I felt as a public now person in my public role I was willing to support them in those efforts.

I think the -- Well, will you repeat your question again, Zach?

Q. My question is, had you known at the time, on May 18th, that the eight point document was being solicited or requested for use in a lawsuit by private individuals against the Governor's stay at home order, had you known that, how would you have reacted to the request?

A. I think that's an important point you're making.

At no time was it intimated in any way that this might be used by private individuals. At all times it was represented to me as in their public roles.

I believe if I was aware that this document was to be used in a lawsuit, I would have consulted counsel prior to signing the document.

MR. JONES: So, I think this would probably be a good time to take a break, for water, use the restroom. I know your time is valuable so I don't

want to take any longer of a break than you would like. So, five minutes, 10 minutes.

We can go off the record.

THE WITNESS: Okay. Five minutes is great.

(Short recess).

MR. JONES: We are back on the record after a short break.

Q. Dr. Butler, I'd like you to find tab D, which we're going to mark as Exhibit 3. It begins on page 58. And don't put Exhibit 2 too far away because we're going to come back to it.

A. Tab D, page 58 marked as Exhibit 3. So marked.

(Deposition Exhibit Number 3 was marked for identification).

Q. (BY MR. JONES:) Okay. And Exhibit 3, Dr. Butler, is labeled a "Declaration of Marc Straub in Support of Motion For Temporary Restraining Order."

Do you see that?

A. Yes.

Q. Okay. Have you ever seen this document before?

A. No.

Q. Okay. Why don't you take a chance to --

just read through actually the entirety of the declaration so that you have a sense of what it says as a whole, and let me know once you are finished and then we will talk about it.

(Pause in the proceedings).

A. I have finished the declaration.

Q. Okay. Thank you, Dr. Butler. So, you will see that this declaration from Mr. Straub attaches various exhibits, A, B, C and D.

Do you see that?

A. Yes.

Q. Okay. So, this can get a little confusing. So now we will have exhibits within an exhibit. In addition, the lettered exhibits attached to Mr. Straub's declaration are out of order. So, and they're written in his writing with quotation marks, Exhibit A and Exhibit B, etc.

So I'm going to try to refer to those sub exhibits as Sub-Exhibit A, Sub-Exhibit B, or handwritten exhibit, but just so we know and so the record is clear, that's how I'm going to refer to these exhibits within Exhibit 3.

Does that make sense?

A. Yes.

Q. Okay. So, if you will turn to Exhibit B,

Sub-Exhibit B on page 63 --

A. Yes.

Q. -- of Exhibit 3. So this is an e-mail from you to Mr. Straub on, dated May 18, 2020 at 4:34 p.m. Is that right?

A. Yes.

Q. And this is in response to Mr. Straub's e-mail at 3:48 p.m., which is on page 64, and we also discussed it in Exhibit 2, in which he attached the eight point document that he says the Douglas Board of County Commissioners requested you to sign.

Is that right?

A. Yes.

Q. Okay. So, in this e-mail that you sent at 4:34 p.m., you wrote, and just follow along while I read aloud, "Please provide some clarification:

"#2 - I am unaware of a plan for dealing with endemic influenza, and unclear how that relates at all to COVID-19. Can you explain how #2 adds strength to the document?"

Did I read that right?

A. Yes.

Q. So, what did you mean that you were unclear how that relates at all to COVID-19?

A. At that time I was unaware that the Health

District had a Pandemic Influenza Plan. I also couldn't imagine how it was important that we had such a plan since COVID-19 is not influenza.

From a medical perspective, they are extremely different. Extremely? They are very different.

And again, my impression at the time was that he was trying to build a case regarding my impression of our local capacity to tolerate further opening the economy, and I couldn't understand how mentioning that we had a Pandemic Influenza Plan would be helpful in that regard.

Q. When you say influenza and COVID-19 are very different from a medical perspective, what do you mean?

A. Influenza, at least in the strains we were most accustomed to, is well-known to us, we now have vaccinations against it. We understand its transmission well.

COVID-19, even though it's an old virus, this novel form of the coronavirus is very poorly understood to us. We do not understand -- we did not at that time, bit by bit we are learning more, but we essentially do not understand well how it is transmitted.

There are no immunizations available to us.

Certainly both our viral infections, both as far as we knew at that time were transmitted primarily in a respiratory route via droplets.

It appeared at that time and still that COVID-19 is dramatically more infectious. I've seen reports between three and 12 times more infectious.

I am not aware that typical influenza strains have a significant asymptomatic transmission or significant portion of the population who are asymptomatic throughout.

I would say that we haven't studied that. It could be true. But since we have a very different approach to influenza, we have not needed to study that to date.

So, again, to my medical mind they are very different viruses which create a very different infection, and especially once people get very sick in the hospital, it's an entirely different infection.

Q. Why do you say it's an entirely different infection once they're sick in the hospital?

A. COVID-19 in a small subset of patients, typically the elderly and medically frail, appears to cause a massive immune response, and it is that immune response that in essence causes multisystem organ

failure.

I have never heard of that previously with viral infections. I have certainly never heard of it related to influenza.

In my career, I have cared for hundreds and hundreds of individuals with influenza. Within the hospital I have certainly cared for dozens of elderly sick people with influenza.

And I have never cared for a patient with influenza who has had an illness course similar to what I have read about with COVID-19.

Q. Thank you, Doctor. When you say "massive immune response," are you referring to a cytokine storm?

A. Yes.

Q. Have cytokine storms been observed in COVID-19 patients who are not medically frail and not elderly?

A. I believe that has occurred. I have not attempted to keep up with that particular literature.

Q. Okay. So, you mentioned that at the time you were not aware of the Health District's Pandemic Influenza Plan.

Is that right?

A. Correct.

Q. Are you now aware of it?

A. I'm aware that it exists, yes.

Q. Have you familiarized yourself with it?

A. No.

Q. Okay. Returning to your e-mail at 4:34 p.m., this Sub-Exhibit B in Exhibit 3 --

A. Yes.

Q. -- I'm going to continue reading. Just read along silently as I read aloud.

"#6 - Would you please clarify what you mean by 'our pandemic plan'? I have not seen a written pandemic plan? Could you send it to me?"

Did I read that correctly?

A. Yes.

Q. Did Mr. Straub eventually send you the pandemic plan -- the Influenza Pandemic Plan?

A. Yes.

Q. Okay. Continuing with this e-mail, number 8, just continue to read along silently while I read aloud.

"#8 - I think what you are looking for is a statement that right now, from a health system standpoint, we have plenty of capacity to experiment with various levels of/types of reopening. I agree with that. To say 'we are prepared for and capable of

dealing with the current threat of public health posed by COVID-19, as well as any other present and anticipated public health threats,' feels a little expansive."

Could you explain why you thought that that sentence felt a bit expansive or a little expansive?

A. Because COVID-19 is novel and we have no prior experience, we are very much learning on the run in coping with new challenges as they are presented to us.

So, when the statement reads "we are prepared for and capable of dealing with the current threat," I could affirm that with my understanding of the current threat, that is, the threat as it had already become apparent to me, I could agree with that statement.

However, certainly I might be ignorant of aspects of the current threat.

And then it goes on, "as well as any other present and anticipated public health threats."

And for me that is just a bridge too far. I cannot anticipate any other present and anticipated health threats.

And I was unwilling to say that I was, you

know, that our healthcare system could accommodate them, because, again, that's just -- it's too much. It's too broad, too expansive.

Q. Thank you, Doctor. So, the next few sentences of your e-mail, this is at the top of page 64 of Exhibit 3, you write, "I actually do NOT," capital NOT, "feel comfortable that I fully understand the present health threat. I am learning more about it every day. It is the 'tip of the iceberg' analogy. I have no way to assess (today) how much of the iceberg I can see."

What did you mean by the tip of the iceberg analogy?

A. Well, I think all of us are probably familiar with that analogy.

I have made in many of the educational talks and meetings I have had with local health care officials and business members and on the local radio that the COVID infection within our community, we can only see the tip of that iceberg, and that is made apparent to us through testing.

We can see the number of people who have tested positive. We cannot easily see all of the rest of the population who's carrying the virus and contagion within the population.

So, I am describing that as the portion of the iceberg which is under water and invisible to us.

So, similarly, even though we can see the current health impacts and the way they are currently impacting our healthcare system, we are not fully aware of the burden of disease within our jurisdiction and just how it could potentially impact our healthcare system.

Q. Are you familiar with the term super-spreader?

A. Yes.

Q. What does it mean to you?

A. To my mind a super-spreader would be an individual who manages to transmit the virus to a number of other individuals far above the standard R value.

So, typically the examples I'm aware of would be an individual who attends a choir practice where there are 60 odd individuals present, who one of whom is present and two hours later I believe 50 odd are positive.

So, in a closed room while singing for several hours, one individual can spread the virus broadly to multiple other individuals.

I believe that is what's meant by the term

super-spreader.

Q. And does part of the tip of the iceberg analogy encompass that potential where despite what you think you know at a given time, that everything can sort of turn on a dime in terms of the response to the virus, and based on one or maybe even two super-spreader events, that can change the entire trajectory of the public health conditions and response needed?

Is that -- Are you in agreement with that?

A. Yes. I am mostly in agreement with, that things can turn on a dime, that we can rapidly encounter things that we've never seen before and we need to cope with.

A super-spreader would be an example of that, although that was not -- that specific example was not in my mind as I wrote this e-mail.

Q. Understood. Turning to sub-Exhibit C, which is before Exhibit B on page 63 of Exhibit 3. Let me know when you see where sub-Exhibit C is.

A. I'm with you. Yes.

Q. Thank you. So, Mr. Straub responds to you, "Thank you, Dr. Butler. I've attached the CDHD Pandemic Flu Plan that originated - as I understand - as a result of legislation in 2006."

Do you see that?

A. Yes.

Q. And do you recall whether he did attach that Pandemic Flu Plan into this e-mail?

A. Yes, he did.

Q. Okay. Now if you could turn to -- I'm sorry. This e-mail, Exhibit C, was sent on Monday, May 18th, 2020 at 6:13 p.m.

Do you see that?

A. Yes.

Q. Okay. Now if you would turn to sub-Exhibit D on the next page, page 64 of Exhibit C.

A. Yeah. I believe you're on 65.

Q. Thank you. 65 and 66 actually of Exhibit C -- of Exhibit 3. I knew this would get confusing.

So, this is an e-mail -- Sorry. Please turn to page 66, which is also part of Sub-Exhibit D.

A. Okay.

Q. And this is an e-mail from you saying "Here you go!" And it indicates that there's an attachment, MBMB Statement for MS 5.20.2020.

What was this e-mail, if you recall?

A. This was me delivering to Mr. Straub the final iteration of the eight point document that he had created for me to sign.

Q. Understood. And if you look at the e-mail

thread below that e-mail as well as on page 65, take a second to familiarize yourself with those few e-mails there in sub-Exhibit D. And let me know once you have finished.

(Pause in the proceedings).

A. Okay. So, I have reviewed all of them. They are a little bit out of order, I believe. But carry on.

Q. They are. So, I guess, you know, it looks like, somehow between May 18th at 6:13 p.m. in Exhibit C, when Mr. Straub e-mails you the Pandemic Flu Plan, and May 20th -- excuse me -- yeah, May 20th, 2:38 p.m. when you provide the eight point document, somehow in between those two events you had agreed to provide the eight point document.

Is that correct?

A. Yes.

Q. So, in reviewing these sub-Exhibits B, C and D, based on your recollection do these constitute the entirety of the e-mails between you and Mr. Straub on this subject?

A. My recollection is that on the day of the board meeting he sent me his eight point plan.

I reviewed it. I sent back the questions that you read through. I asked him if he could provide

said, "That looks fine."

I said, "Do you want it on letterhead or signature or what?"

He said, "Fine, on letterhead, with a digital signature."

And I provided that back to him.

I do recall that there seemed to be some time pressure. Again, to my mind that didn't make good sense. He wanted this I believe by Tuesday or Wednesday.

One of the issues I had with the pandemic plan that he sent me was that in total it was over 300 pages long. I did not feel I could adequately review it in 48 hours.

But I do remember being curious as to the time pressure that was involved.

Nonetheless, I was hoping to be as forthright, transparent and helpful as possible. And so we worked on and I finally signed the final product that was provided to him.

Q. Okay. So, I'll represent to you that the lawsuit to which Mr. Straub was the plaintiff, Sutton vs. Inslee in Douglas County, was filed on May 22nd, 2020.

Knowing that, does that make more sense to

the pandemic plan.

He did that.

Thereafter, again, because I felt he was interested to know my personal position, I created a statement that outlined my personal position, and I sent that to him, hoping that it would meet the need.

Again, the eight points felt very awkward. I could not understand again how that would be as helpful as having my narrative. So I provided that to him.

To my surprise he responded, "Thank you. I appreciate that, and would you still sign the eight point plan?"

And, again, I did not know this had been built specifically to support a lawsuit. Now I am aware that that is the case, or it certainly has appeared to me that that is the case. And it appears to me that that was the reason why he was not interested in my actual narrative.

So, I again, hoping to please the Commissioners who are now my new supervisors in this role, I went through and edited the eight point document in a way that I felt I could sign. I did --

I sent it back to him. He looked at it. He

you now as to the time constraints that were apparently being brought to bear?

A. Yes, absolutely.

Q. Let's turn to Sub-Exhibit A of Exhibit 3.

A. On what page?

MR. ZIMMERMAN: 62.

Q. (BY MR. JONES:) It's on page 62.

A. Thank you.

Q. So, what is this document, sub-Exhibit A?

A. This is the final product of the eight point plan that I returned to Mr. Straub on my Columbia Valley Community Health letterhead with my digital signature.

Q. Okay. I'd like to just go over some of these points in here.

Point number 2 on page 62, sub-Exhibit A, says "I am aware that, pursuant to Chapter 70.26 RCW, the Chelan-Douglas Health District developed a plan for dealing with pandemic influenza in 2008.

Do you see that?

A. Yes.

Q. And what was that statement based on?

A. Again, I had been presented an eight point plan. The second point of that original -- plan? Sorry. Document.

The second point of that original document referenced this Pandemic Flu Plan. I had been made aware that it existed, and Mr. Straub appeared to want this in the document.

Again, it was unclear to me why it was helpful. But I was willing to provide it as it is a true and correct statement.

Q. Okay. When you say "it is a true and correct statement," was your statement based on anything other than the information that Mr. Straub had provided?

A. At some point I did confirm with Barry Kling, the administrator of our Health District, that the Health District had created an Influenza Pandemic Plan. It was a brief, less than one minute conversation and in a much longer conversation, and he confirmed it. I do not recall the date of that conversation.

But there was that conversation, and the fact that I had the document in hand that made that a true and correct statement.

Q. Understood. If you look at point number 6 where you raise, "Based on current knowledge, we do not anticipate a shortage of hospital or other health care resources to deal with the COVID-19 pandemic."

Do you see that?

A. Yes.

Q. Why did you include "based on current knowledge" in there?

A. Very similar to the discussion we just had about the iceberg. I wanted to clarify, or at least fortify my position, protect myself, by clarifying that based on what I know right now I am comfortable making this statement. But I could not predict what might happen later today or tomorrow.

Q. And point number 7 says "If permission were granted, our office would impose fewer restrictions on residents within the boundaries of the Chelan-Douglas Health District that are currently imposed by the Governor's proclamations."

Do you see that?

A. Yes.

Q. What did you understand that sentence to mean?

A. What was very clear to me as I composed this, and still today, is that we are operating under an emergency order of the Governor. That is, as I understand it, the law. And I need to operate within that proclamation, that law, if you will.

We have repeatedly and persistently had

pressure from our local community, from the members of the Board of Health to operate outside that guidance, to make exceptions.

And I will point out, it's probably clear to all, the Governor's proclamation was a one-size-fits-all, and it has not fit particularly well in my local health jurisdiction. And I am absolutely empathic to the disparities and unfairness as it has been imposed.

However, I'm equally clear that that is the law in effect, and therefore I preface number 7 different from the original way it was written, "If permission were granted."

I do, I did, I still do believe that our office would impose fewer restrictions on residents within our boundaries than are currently in the Stay Home - Stay Safe proclamation.

Q. Stay Home - Stay Healthy?

A. Thank you.

Q. When you say the proclamation is a one-size-fits-all, are you aware that there's a variance program and a reopening program, and now well over half of Washington counties, the vast majority, in fact, are operating in different stages of reopening?

A. Yes. I am aware of that.

Q. So, is it really fair to say it's a one-size-fits-all proclamation?

A. Yes.

Q. Why is that?

A. The proclamation has various phases and stages to which different counties can move, based initially on a transmission rate of less than -- Well, based initially on the county's population needing to be less than 75,000, and subsequently on the number of positives and the transmission rate within the county.

What is clear to me is that the disease is behaving differently in Western Washington than in Eastern Washington.

In Eastern Washington, although we have had a lot of transmission, we have not had a similar amount of morbidity, as has been seen in the western side of the state. We have happily had very few hospital admissions and very few deaths.

I cannot explain why it is behaving differently in our rural populations than in the more urban western side of the state. But it is fairly clear that it is.

We did apply, even though we did not qualify for the initial variance, we made an application which

was promptly returned to us. And we have subsequently, on Friday last, two days ago, submitted a second variance proposal.

Q. And you're aware that under the phased reopening plan, there's no population requirements in terms of which counties are eligible.

Correct?

A. In the current iteration, that is correct.

Q. And the variance proposals allow for tailoring and tinkering based on local conditions, wouldn't you agree?

A. No. The current variance proposal allows for that, not the proposals. Right, Zach? The first one did not allow for tailoring --

Q. No. My question is just that, for example, the proposal that Douglas, that Chelan-Douglas submitted, it doesn't exactly map onto phase 1, phase 2, phase 3.

It's some features of phase 1 and some features of phase 2, isn't that correct?

A. That is correct.

Q. So, wouldn't that reflect tailoring to local conditions for that individual variance plan?

A. Well, inasmuch as it was rejected, it would have --

Q. I'm talking about the second -- I'm talking about the second proposal.

A. Yes. If the second proposal is approved, then I agree with your statement, it does allow for a degree of tailoring, yes.

Q. So, in going back to this point 7 where you say "our office would impose fewer restrictions on residents within the boundaries of the Chelan-Douglas Health District than are currently imposed by the Governor's proclamations," is that comparison to what the current status quo is for Chelan and Douglas Counties, or to what the conditions would be if the variance proposal is accepted?

A. I'm sorry, I do not recall the date of the initial variance proposal being submitted.

When I constructed this document, it was meant to mean that there would be fewer restrictions than were currently in place at the time I constructed it.

Q. Understood. So, in a world, hypothetically, if the current pending Health District variance proposal is accepted, would that represent what the Health District would do, kind of left to its own devices?

A. Zach, I don't think I can answer that with a

yes or a no. I would say the current variance proposal, we were provided a fairly strict template to follow in completing that. And we were provided fairly specific examples that we might choose from.

I think it was -- It's very reasonable the way it was presented to us. And I think the examples were quite reasonable.

Had it not been presented in that way, I do not think we would have returned it written as we did.

For example, it says things like, you know, certain businesses will be allowed at 25 percent occupancy.

We probably would not have used that parameter in our document.

It would have been largely similar, yes. It would not have been just the same, no.

Q. Understood. Well, let me change the hypothetical slightly. Let's say the variance proposal is adopted, and then the Governor's proclamation is lifted.

Can you identify a specific change that the Health District would adopt in its own reopening plan, compared to what the variance proposal reflects?

A. Well, there's a lot of hypotheticals here,

Zach.

Q. Understood.

A. And let's just all agree that we're talking in hypotheticals here, and I hope they are valuable to you in some way.

If I was allowed to make changes that I felt were best -- would best fit our community, I would not have allowed large box stores such as Target or Costco to remain open, selling all of their wears, simply because they also sold groceries, which are considered essential.

That has put a huge volume of the population inside those constrained spaces, and has not allowed other retailers of other materials sold by Target and Costco to also be open to the public.

That is overtly unfair. And that I think has caused a great deal of -- It has made it difficult for the population to keep itself safe by embracing the Governor's proclamation.

I feel that if people saw that it was more fairly imposed, and especially enforced, there would be much greater acceptance.

And unfortunately, we're left with a lot of anger and backlash to the point where people aren't willing to even follow what I think are medically very

easy and justifiable precautions, such as wearing a mask, because they're trying to make an act of civil disobedience to their own peril.

Q. Would you say that the Stay Home - Stay Healthy proclamation has been widely complied with in Chelan and Douglas County?

A. "Widely" is a vague term. But I would say if by widely, you mean more than half the population, I would say yes.

Q. Thank you, Doctor. Sir, I'd like you to turn now to what's tab R, and I hear a little bit of background noise. I'm not sure if one of the participants isn't on mute. But I do hear some strange background noise. It looks like everyone is. But I don't know what it is.

A. I am going to make sure -- No. It says telephone. Can you hear me still?

Q. No, I can't hear you.

A. Okay. So, tab R will be Exhibit 4.

MR. ZIMMERMAN: Page?

MR. JONES: Page 204, the pages begin 203 is where the exhibit tab is.

THE WITNESS: Tab R is Exhibit 4, page 203. So labeled.

(Deposition Exhibit Number 4 was

marked for identification).

Q. (BY MR. JONES:) Okay. So, Exhibit 4, which you have in front of you, is an e-mail from you to Mr. Straub on May 19th at 5:03 p.m.

Please take a look at this e-mail at the top there and let me know once you have finished reviewing it.

(Pause in the proceedings).

A. All right.

Q. So, this e-mail is in the same e-mail thread that we looked at in Exhibit 2 and 3.

Correct?

A. Yes.

Q. But this e-mail from you and its attachment is not contained in either Exhibit 2 or Exhibit 3, is it?

A. I believe the attachment is on page 207.

Q. Sorry. My question is, this e-mail from you on May 19th --

A. Okay.

Q. -- is not contain in either the earlier exhibits we were discussing, Exhibit 2 or Exhibit 3?

A. Okay. I believe that is correct. Yes.

Q. So, even though it was part of the same

e-mail thread, this was omitted from the e-mails in Mr. Straub's declaration?

A. I know nothing about that. I don't know what or why the prior exhibits were submitted or how they got ordered in that way. But this does not look like it is contained in anything we've looked at so far.

Q. Understood. So, at the top of this e-mail you write, "Marc, the attached is for your eyes only. I would like to share with you my full and honest approach to this pandemic. I am hoping that this will fill the needs of those who you were representing when you suggested the eight points for me to sign."

Why did you write that "I am hoping that this will fill the needs of those who you were representing when you suggested the eight points for me to sign"?

A. Yes. As I've mentioned previously, it was -- I mean, I was blindsided at the meeting by the eight point document. I had no idea what it was for.

Mr. Straub explained it was so that the Douglas County Board of Commissioners could use it in their future work.

My suspicion was that he was interested to

know my actual position on things. It was the only reason I could think of.

Again, in retrospect, that's not what he was after. The document appears to have been pre-constructed specifically to support his lawsuit.

But when I wrote this e-mail I presented to him my full narrative and my approach to where we were at that moment.

Q. And in the next sentence you wrote "I am trusting you not to take advantage of my being vulnerable in this way with you."

What did you mean by being vulnerable?

A. Well, if you read the attachment, you will see that I talk about a need to tolerate a certain amount of mortality and morbidity.

And I think that taken out of context could reflect very badly on me.

Within the context, I believe it is correct and accurate. But it certainly, he could have taken advantage of me by releasing portions of that document out of context.

Q. Understood. So, at the bottom of the e-mail you saw -- Oh. I'm sorry. Sorry. Before I get there.

So, what was the paper that you attached?

Why did you attach the paper that you describe as a physician paper?

A. Again, it was my belief that Marc and his constituents were interested in discovering my view of the pandemic and our capacity, our local capacity, to further open the economy.

Q. And then you wrote, "If it weren't -- "If we weren't in the midst of this craziness, I would invite you out for a beer to discuss all of this more fully. Without that, it would be best for the two of us to discuss this by phone prior to involving others.

"You could call me tonight at 509," and then your phone number's in there, and we have redacted your phone number, just in case this document makes it into a public court filing at any point.

So, did you ever speak with Mr. Straub by telephone?

A. Yes.

Q. What did you discuss?

A. It's probably apparent just based on all these documents when it happened, and I'm not remembering right now.

But in essence I just wanted to talk through with him the problems I had with the eight point document.

That's right. This e-mail came following my capacity -- following my having reviewed the Pandemic Flu Plan. It was 300 pages long. There was no way I was going to do that.

I said, you know what, he's got these eight points. In order to put my signature on that document, I would need to have read the 300 pages. I can't do that. So, I provided, here's my statement of how I actually feel.

But I knew I was fishing. There was something going on here, and it was unclear to me why this was happening the way it was.

And the point I was trying to make was, let's just talk about this. Tell me what you need, let me be helpful. Because it felt to me like I wasn't hearing everything that he needed, everything that was on his mind or on his plate or what his constituents needed from him or whatever.

Certainly it is my practice, and in the clinic that I have built, this is how we communicate. We talk to each other. We have high degrees of trust. And we work together cohesively as a team for the good of the population we serve.

It was my expectation that Mr. Straub would be interested in doing the same thing.

And, so, yes, we did have a phone call.

He said, again, "I just need you to sign the eight points."

And I went through and said, "It's going to look kind of stupid, because none of these really make good sense."

He said, "Just write whatever you can, something that you can sign and support, and get it to me. And if you can get it to me by Wednesday, that will be great," or something to that effect.

Q. Okay. But you did speak with him on the telephone?

A. Yes.

Q. And in your call on the phone did he provide the additional context of the potential of the new lawsuit being filed with him as a party?

A. Not at all. No. He actually had very good opportunity to do exactly that, and he did not take advantage of that opportunity.

Q. If you will turn to another exhibit, this is tab P, it will be Exhibit 5.

A. Give me a page when you have it.

Q. 195.

A. Tab P, page 195 is Exhibit 5. So marked.

(Deposition Exhibit Number 5 was

marked for identification).

Q. (BY MR. JONES:) Okay. So. Dr. Butler, you have Exhibit 5 in front of you.

Right?

A. Correct.

Q. And this is an e-mail from Mr. Straub to you dated Wednesday, May 20th, 12:07 p.m. And it is a response to your e-mail that we just discussed in Exhibit 4 where you attach the position paper describing your own thoughts on the pandemic.

Is that right?

A. Yes.

Q. Okay. And if you will look below, let's see, kind of in the middle of the page with the paragraph beginning "We're simply asking."

Do you see that?

A. Yes.

Q. Okay. And he writes, "We're simply asking that - as the CDHD Medical Officer - you sign a statement that includes the following points to the extent you're comfortable."

And then below there, there's those eight points again that's written into the body of the e-mail.

Do you see that?

A. Yes.
Q. Okay. So, what I'd like to do is I'd like to take those eight points and compare those to the final letter that you signed which is in Exhibit 3. So, if you can grab Exhibit 3 again.
A. Can you give me a page number?
Q. Yes. That's page 62.
A. I have it.
Q. And I just want to compare those two documents side by side to look at the changes that were made before the final version of that letter.
(Pause in the proceedings).
A. Okay.
Q. Okay. So, the first point, it looks like in Exhibit 5 Mr. Straub wrote "I am the Regional Health Officer for the Chelan-Douglas Health District."
And then on Exhibit 3, point 1, you write, "I am the Health Officer for the Chelan-Douglas Health District."
So you deleted the word "Regional." Is that right?
A. Yes.
Q. Why did you do that?
A. My correct title is Health Officer, not Regional Health Officer.

Q. Okay. So, turning to point 2. In Exhibit 5 Mr. Straub wrote "Pursuant to Chapter 70.26 RCW, the Chelan/Douglas Health District developed a plan for dealing with pandemic influenza."
And then if you turn to Exhibit 3, point 2, it is the same sentence, except you add "in 2008" at the end.
Do you know why you did that?
A. I also added "I am aware that."
Q. Hmm. Thank you.
A. I did both of those, because later it refers back to this document, and I wanted to clarify that I had not written nor was I familiar with the contents of the document, but I could attest that it existed.
Also on the cover of the document the date of creation is 2008.
And I put that in there honestly in an effort to point out that this document is 12 years old. Because, again, to my mind it makes no sense to be referring back to this document. So, that was why.
Q. Understood. Point 3 you write -- Well, excuse me.
Point 3 in Exhibit 5 Mr. Straub wrote "COVID-19 is 'a new virus' that 'causes serious

illness, and then spreads easily from person to person'."
And it look where you wrote in Exhibit 3, or point 3 is the same but without the quotation marks.
Is that right?
A. Yes.
Q. Do you know why you deleted the quotation marks?
A. They are unnecessary and they make -- would make me appear uneducated.
Q. Understood. Number 4. Excuse me. I'm going to skip over 4.
And let's go to 5. Point 5 from Exhibit 5, Mr. Straub -- Actually, I think it would be easiest if you would just read point 5 to yourself, and then read point 5 in Exhibit 3 to yourself, and then we will talk about them.
Does that make sense?
A. Yes.
Q. Okay. Let me know when you are finished.
(Pause in the proceedings).
A. Okay.
Q. So, it appears, comparing these two documents that in Exhibit 3 for the final version you deleted in point 5 quote "our health care resources at

present are adequate to deal with the expected number of COVID-19 cases," and replaced it with, "our health care resources at present are adequate to begin reopening our economy."
Did I read that right?
A. Correct.
Q. Why did you do that?
A. To make it more specific and less expansive. I can state that our health care resources at present are adequate. But I have no foreknowledge of how many COVID-19 cases should be expected into the future.
I felt the goal of this document was to support reopening the economy, and I did and still do feel that our health care resources are adequate to begin reopening the economy.
I was uncomfortable attesting that our health care resources at present are adequate to deal with the expected number of COVID-19 cases, because I do not know what the expected numbers are.
Q. Understood. Point 6 in Exhibit 5 Mr. Straub wrote, "If our pandemic plan is followed, we do not anticipate a shortage of hospital or other health care resources to deal with the COVID-19 pandemic."
And you replaced that with, you deleted the reference to the pandemic plan and said in Exhibit 3,

"based upon current knowledge, we do not anticipate a shortage of hospital or other health care resources to deal with the COVID-19 pandemic."

Is that right?

A. Yes.

Q. Why did you delete "If our pandemic plan is followed" and replace it with "Based upon current knowledge"?

A. Yeah. In short, not to look stupid. Again, we've discussed this previously. I had no knowledge and had not had the time to review the Influenza Pandemic Plan, which is what I believe he was referring to in number 6. And thus I couldn't comment on whether following that plan would keep us safe.

But also it felt, from a medical standpoint, it was ridiculous to refer to an Influenza Pandemic Plan as we are confronting a novel virus and thus a novel pandemic.

So, I tried to rephrase that in a way which I could attest to, which was that based upon our current knowledge we do not anticipate a shortage of hospital or other health care resources to deal with the COVID-19 pandemic.

Q. Thank you. And in point 7 you also deleted Mr. Straub's reference to the pandemic plan, is that

right?

A. Yes.

Q. And did you do that for similar reasons?

A. Yes.

Q. Finally, in point 8 it appears as though you deleted from Mr. Straub's version in Exhibit 5, quote, "As well as any other present and anticipated public health threats," and replaced it with in Exhibit 3, "as well as the additional threat posed by a phased reopening of the economy."

Is that correct?

A. Yes.

Q. Why did you make that edit?

A. As we have discussed previously, number 8 to my mind was too expansive.

In medicine we learn, always remember never say "always" or "never." I'm sorry. Right. Always remember never say "always" or "never."

And that just rings of that. Here we are, "any other present or anticipated," that to me goes against some of the maxims of medicine, and certainly against the maxim of a pandemic.

So I removed that expansive statement and replaced it with something I could support.

Again, I felt this was to support the

Douglas County Board of Commissioners' efforts to reopen the economy, which is why I added that, because I thought that was a threat that they were coping with, "the additional threat posed by a phased reopening of our economy.

Q. Thank you, Doctor. At some point did you learn that your signed statement here in Exhibit 3, Sub-Exhibit A, was used in multiple pending lawsuits?

A. Yes.

Q. Do you recall when you did learn that the statement was used in various lawsuits?

A. Without looking at a calender, I couldn't tell you the date. I can tell you it was at about nine o'clock in the evening when one of my providers messaged me with a concern that a Facebook post had been sent to her. I believe it came out of Cashmere, Washington.

And somebody had reported Chelan and Douglas Counties had sued the Governor and that Dr. Butler was supportive of this action.

And my provider understood that that would not have been the case, and thus brought it to my attention, because she was concerned that now on social media I was being represented as supportive of the lawsuit which had been brought against the

Governor.

Q. Understood. And what did you do when you found that out?

A. I responded first to my provider. I thanked her and said I would look into it.

Then of course everything became blindingly apparent. You know, the way this was brought forward, the eight points, the unwillingness to accept my narrative.

Declarative statements in favor of going back to the eight points made much more sense.

So, for whatever reason I thought that it was Dan Sutton who had brought the initial proposal forward.

Without going back to check any notes, I e-mailed Dan and asked him if he had used my statement in a personal lawsuit brought by him against the Governor.

And he responded to me that he had never handled that document.

And at that point I forget exactly what I did. I must have looked back in some way and realized that it was Marc Straub.

I know what. I went back and looked at the e-mail exchange that we had had, realized that the

e-mail exchange was with Marc.

And then I sent the same e-mail to Marc, asking him if he had used the declaration that I had provided to him in his public capacity in a private lawsuit that he had brought as an individual citizen against the governor.

Q. And did he respond to that e-mail?

A. He did not respond directly to me. He subsequently launched an e-mail to the entire Board of Directors, which included a copy of that e-mail.

Q. This is the last document I want to bring up with you. Sometimes those can be famous last words. But this is tab ZZZ. This is the one that was loose. So it was just printed earlier this morning. And it's unnumbered. So, this will be Exhibit 6.

A. So marked.

(Deposition Exhibit Number 6 was marked for identification).

Q. (BY MR. JONES:) Okay. Great. You're a pro at this now, Dr. Butler.

Is this an e-mail that you were just referring to, that you sent to Mr. Straub?

A. Yes.

Q. And the subject line of this e-mail is "Deceit"?

A. Yes.

Q. Why did you chose that phrase for a subject line?

A. It was my impression on that evening that Marc, Mr. Straub, had had multiple opportunities to clarify his intentions to me. That if we were colleagues, working as a cohesive team for the good of our local health jurisdiction, he would have approached me individually, made clear the needs that he had for his personal lawsuit, and asked me if I could support it.

Instead, what appears to have happened was that he deceived me into believing that he needed this statement to support work that was being conducted by the Douglas County Board of Commissioners. That is why I used the word "deceit."

Q. Understood. Knowing what you know now, that your statement was used in actually three lawsuits of which I am aware, brought by private individuals against the Governor's proclamation, would you, if you could, retract the statement from the record?

A. I believe that the statement is true and correct as signed.

What is difficult for me, number one, is I am not accustomed to working with other individuals who

I feel are responsible for the public health of our community in such an awkward, back-handed manner.

Again, we're in the age of COVID-19. I've never met Mr. Straub. If we'd been at board meetings together, it'd be different. Maybe nothing would have happened the same way.

But in the current circumstances, what is most upsetting and frustrating to me is the way that the information was gained from me with clear forethought and planning to be used in a way that was not made clear to me.

Knowing what I know now, would I retract it?

I think I can probably get over the disappointment I feel in the way that Mr. Straub behaved.

But the public as I now understand is -- I'm sorry, the document as I now understand is a public document, and I stand by its contents.

So, no, although I feel I was a little bit hoodwinked in getting it into those lawsuits, I don't feel I have any grounds to retract it.

Q. Do you have any concerns that the statement even as revised might be taken out of context to suggest facts that aren't necessarily true?

A. I'm concerned that it reflects my support of

a lawsuit against the Governor and his proclamation, and I would not participate knowingly in such a lawsuit as a private citizen.

Q. Why?

A. Why?

Q. Why not?

A. I feel the Governor's actions have been thoughtful and correct.

I am frustrated that they have not been enforced fairly. And I feel that there unfortunately has not been enough plasticities as the pandemic has rolled out to allow us locally to be as nimble as we would have wanted to be.

That said, I believe the governor acted with the best information available to him, and I have no concerns about the Governor's actions. So, I would not have brought a lawsuit against him.

Q. Understood. I know I mentioned that your statement had been used in at least three lawsuits challenging the Governor's proclamations.

Have you, other than what we have reviewed today, have you reviewed any of the pleadings, the legal papers in those lawsuits or otherwise familiarized yourself with the subject matter of those lawsuits?

A. The only document I reviewed was Cuevas vs. Jay Inslee, and I believe that was the Chelan County document. That's the only one I have seen.
Q. And did you review the Complaint in that lawsuit?
A. If they were -- If the Complaint was included in the verbiage of the document, then, yes, I would have reviewed it.
Q. Okay. Turning to Exhibit 3 again, your statement in number 2 which says, it references Chapter 70.26 RCW.
Do you see that?
A. Can you tell me what page you are on, Zach?
Q. Oh, I am sorry. It's page 62 from Exhibit 3.
A. Yes.
Q. And do you see in point 2 there is a reference to that chapter of the Washington -- the Revised Code of Washington, 70.26?
A. I see that, yes.
Q. Did you ever review that chapter of the code?
A. No.
Q. Okay. So, I'll represent to you that this is a chapter of the Revised Code of Washington entitled

Pandemic Influenza Preparedness.
And I think it's a fair summary of this lawsuit -- of several of the lawsuits in which plaintiffs are challenging the proclamations, that their view, plaintiffs' view, that this chapter displaces or lessens the Governor's authority under his executive, general executive powers to issue the proclamation.
Does that make sense? Do you understand that description?
A. Yes.
MR. DE WOLF: Excuse me. I'll object to the form of the question as misstating the plaintiffs' position, but you can go ahead and answer.
THE WITNESS: Yes.
Q. (BY MR. JONES:) Okay. So, setting aside the legal questions, we don't expect you to interpret the statute for us, setting aside the legal question, in your medical and professional opinion, would a county-by-county approach to the COVID-19 pandemic be a reasonable and effective strategy for preventing or slowing the spread of the disease?
A. No.
Q. Why not?
A. Over the last 27 years of my career I have

seen the local Public Health District emasculated, torn apart. It's probably one-quarter of the size it used to be.
There is just no conceivable way that our local health jurisdiction could have the resources required to understand or manage a pandemic like this.
I believe that the State Department of Health does have access to those resources. It has full-time prepared epidemiologists and public health officers working closely with academic institutions on modeling and guidance which is something that as a family physician I couldn't begin to approximate.
So, there is no way that I would be prepared at a local level to manage a county-by-county for my two counties response without enormous support provided by the State Department of Health.
MR. JONES: I think I may be done, but I'd like to have five minutes to review my material. So, I realize I've gone a little bit longer than I said, but if you will just indulge me for five more minutes to go over my notes.
THE WITNESS: Could we take a time-out?
MR. JONES: Yes. Thank you. We will go off the record now.
(Short recess).

MR. JONES: Okay. Let's go back on the record.
Q. Dr. Butler, I have just one or a few more questions.
We talked a bit about the Health District's Pandemic Influenza Plan.
Do you recall that?
A. Yes.
Q. I think I know what the answer to this next question's going to be, but I have to ask it anyway.
Has the Health District Pandemic Influenza Plan governed the Health District's response to COVID-19?
A. My understanding is that prior to assuming my current position, that plan was used to set up the initial phases of our response.
During my time in this role I have not seen it referred to.
Q. And what was that understanding based off of?
A. I believe a discussion I had with Mr. Kling, and he stated that the Pandemic Flu Plan had been very helpful since they were beginning to school up and decide how they were going to structure themselves to confront this pandemic.

MR. JONES: Thank you, Dr. Butler, for your time and for your service to your community.
THE WITNESS: Thanks, Zach.
MR. JONES: I don't have any additional questions at this time.
MR. DE WOLF: I don't have any questions. I do want to thank Dr. Butler for speaking slowly and clearly. It was very easy to follow him. And you would make an excellent witness.
THE WITNESS: Thank you.
MR. JONES: For the record, I concur.
COURT REPORTER: Zach, are you ordering a copy? Are you ordering this?
MR. JONES: Yes, we were.
COURT REPORTER: Okay. Mr. DeWolf, do you wish a copy?
MR. DE WOLF: Let me reserve that one. I'll get back that you.
COURT REPORTER: Okay. Thank you.

(1:00 p.m.)

STATE OF WASHINGTON)
) ss.
County of Spokane)

I, William J. Bridges, do hereby certify that at the time and place heretofore mentioned in the caption of the foregoing matter, I was a Certified Shorthand Reporter for the State of Washington, and pursuant to RCW 5.28.010, am authorized to administer oaths and affirmations in and for the State of Washington; that at said time and place I reported in stenotype all testimony adduced and proceedings had in the foregoing matter; that thereafter my notes were reduced to typewriting and that the foregoing transcript consisting of 94 typewritten pages is a true and correct transcript of all such testimony adduced and proceedings had and of the whole thereof.

I further certify that I am herewith securely sealing the original deposition transcript and promptly delivering the same to Attorney Zachary Pekelis Jones.

Witness my hand at Spokane, Washington, on this _____ day of June, 2020.

_____
William J. Bridges
CSR NO. 2421
Certified Shorthand Reporter
My commission expires: 11-1-20

CERTIFICATE OF WITNESS

STATE OF WASHINGTON)
)
COUNTY OF CHELAN)

I, MALCOLM D. BUTLER, declare under penalty of perjury under the laws of the State of Washington, that I am the witness named in the foregoing deposition and that I have read the questions and answers thereon as contained in the foregoing deposition, consisting of pages 6 through 94; that the answers are true and correct as given by me at the time of taking the deposition, except as indicated on the correction sheet.

_____
MALCOLM D. BUTLER

Executed on the _____ day of _____, 2020, at _____, _____.
(City) (State)

JOSE LUIS CUEVAS, et al vs. JAY INSLEE
June 8, 2020

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Ex. F

COVID-19

For the latest COVID-19 health guidance, statistics and resources, visit Coronavirus.wa.gov.

Washington Governor - Jay Inslee

Inslee statement on Saturday protests

May 30, 2020

Story

"As people gather today to protest the unjust death of George Floyd, I hope they do so peacefully and safely. Everyone has the freedom - and the right - to demonstrate and speak their mind. However, violence and destruction have no place in Washington state or our country.

"Together, we grieve for the death of George Floyd, and many, many others. The events in Minnesota and across the nation the past few nights have been stunning and illustrate how inequity causes people to lose faith in their public institutions.

"The trauma inflicted on generations of people of color must be acknowledged, and more must be done to correct it. Feeling second-class in one's own community does not make people feel safe. Insecurity hardens into anger.

"I fully support the right to free speech and peaceful assembly. I applaud every Washingtonian standing for what they believe in, but we must do so in a way that allows space for these important and necessary discussions, not in a way that inspires fear.

"If you choose to protest today, please be safe and peaceful. These are important issues that deserve our full attention, without distraction from violence and destruction. Without solutions to inequity, the long road to justice will run even longer."

Media Contact

Public and constituent inquiries | 360.902.4111
Press inquiries | 360.902.4136

Ex. G

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
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Coronavirus Disease 2019 Case Surveillance — United States, January 22–May 30, 2020

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The coronavirus disease 2019 (COVID-19) pandemic resulted in 5,817,385 reported cases and 362,705 deaths worldwide through May, 30, 2020,[†] including 1,761,503 aggregated reported cases and 103,700 deaths in the United States.[§] Previous analyses during February–early April 2020 indicated that age ≥65 years and underlying health conditions were associated with a higher risk for severe outcomes, which were less common among children aged <18 years (*1–3*). This report describes demographic characteristics, underlying health conditions, symptoms, and outcomes among 1,320,488 laboratory-confirmed COVID-19 cases individually reported to CDC during January 22–May 30, 2020. Cumulative incidence, 403.6 cases per 100,000 persons,[¶] was similar among males (401.1) and females (406.0) and highest among persons aged ≥80 years (902.0). Among 599,636 (45%) cases with known information, 33% of persons were Hispanic or Latino of any race (Hispanic), 22% were non-Hispanic black (black), and 1.3% were non-Hispanic American Indian or Alaska Native (AI/AN). Among 287,320 (22%) cases with sufficient data on underlying health conditions, the most common were cardiovascular disease (32%), diabetes (30%), and chronic lung disease (18%). Overall, 184,673 (14%) patients were hospitalized, 29,837 (2%) were admitted to an intensive care unit (ICU), and 71,116 (5%) died. Hospitalizations were six times higher among patients with a reported underlying condition (45.4%) than those without reported underlying conditions (7.6%). Deaths were 12 times higher among patients with reported underlying conditions (19.5%) compared with those without reported underlying conditions (1.6%). The COVID-19 pandemic continues to be severe, particularly in certain population groups. These preliminary findings underscore the need to build on current efforts to collect and analyze case data, especially among those with underlying health conditions. These data are used to monitor trends in COVID-19 illness, identify and respond to localized incidence increase, and inform policies and practices designed to reduce transmission in the United States.

State and territorial health departments report daily aggregate counts of COVID-19 cases and deaths to CDC; these were tabulated according to date of report to examine reporting trends during January 22–May 30. In addition to aggregate counts, individual COVID-19 case reports were submitted via a CDC COVID-19 case report form** and the National Notifiable Diseases Surveillance System (NNDSS).[††]

* These authors contributed equally to this report.

† https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports.

§ CDC official counts of cases and deaths, released daily on https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html, are aggregate counts from reporting jurisdictions. Throughout the COVID-19 pandemic, CDC has been tracking both aggregate and individual (i.e., line-list) counts of cases and deaths. For aggregate counts, from January 22 to March 2, 2020, CDC provided laboratory confirmation for all U.S. confirmed cases. Starting March 3, jurisdiction partners validated aggregate counts each night for report out at 12 p.m. the following day by CDC. For individual counts, jurisdiction partners electronically submit standardized information for individual cases of COVID-19 to CDC. From April 14, aggregate and individual counts included confirmed and probable cases and deaths, according to the Council of State and Territorial Epidemiologists position statement Interim 20-ID-01 (https://cdn.ymaws.com/www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdf; https://wwwn.cdc.gov/nndss/conditions/coronavirus-disease-2019-covid-19/case-definition/2020/).

¶ Incidence was calculated per 100,000 population using 2018 U.S. Census population estimates for U.S. states and the District of Columbia obtained from CDC WONDER (https://wonder.cdc.gov/single-race-population.html).

** https://www.cdc.gov/coronavirus/2019-ncov/php/reporting-pui.html.

†† https://wwwn.cdc.gov/nndss; https://wwwn.cdc.gov/nndss/covid-19-response.html.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Jurisdictions voluntarily report confirmed and probable[§§] cases from reports submitted by health care providers and laboratories. A laboratory-confirmed COVID-19 case was defined as a person with a positive test result for SARS-CoV-2, the virus that causes COVID-19, from a respiratory specimen, using real-time reverse transcription–polymerase chain reaction testing. COVID-19 case data reported from 50 states, New York City, and the District of Columbia[¶¶] were analyzed to examine reported demographic characteristics, underlying health conditions, clinical signs and symptoms, and severe outcomes, including hospitalization, ICU admission, and death. Data were missing for age, sex, and race or ethnicity in <1%, 1%, and 55% of reports, respectively.[***] Cases reported without sex or age data were excluded from this analysis as were cases meeting only the probable case definition, along with persons repatriated to the United States from Wuhan, China, or the Diamond Princess cruise ship. Cumulative incidence was estimated using 2018 population estimates. Because of the high prevalence of missing race and ethnicity data, estimates of incidence and proportions of underlying health conditions, symptoms, and severe outcomes by race and ethnicity were not described. Analyses are descriptive and statistical comparisons were not performed.

CDC received notification of the first case of laboratory-confirmed COVID-19 in the United States on January 22, 2020.[†††] As of May 30, an aggregate 1,761,503 U.S. COVID-19 cases and 103,700 deaths had been reported (Figure).[§§§] The 7-day moving average number[¶¶¶] of new daily cases peaked on April 12 (31,994) and deaths peaked on April 21 (2,856). As of May 30, the 7-day moving average numbers of new cases were 19,913 per day and deaths were 950 per day.

Among the 1,761,503 aggregate cases reported to CDC during January 22–May 30, individual case reports for 1,406,098 were submitted to CDC case surveillance. After exclusions, data for 1,320,488 (94%) cases were analyzed. Median age was 48 years (interquartile range = 33–63 years). Incidence was 403.6 cases per 100,000 population (Table 1) and was similar among females (406.0) and males (401.1).[****] Incidence was higher among persons aged 40–49 years (541.6) and 50–59 years (550.5) than among those aged 60–69 years (478.4) and 70–79 years (464.2). Incidence was highest among persons aged ≥80 years (902.0)[††††] and lowest among children aged ≤9 years (51.1). Among the 599,636 (45%) cases with information on both race and ethnicity, 36% of persons were non-Hispanic white, 33% were Hispanic, 22% were black, 4% were non-Hispanic Asian, 4% were non-Hispanic, other or multiple race, 1.3% were AI/AN, and <1% were non-Hispanic Native Hawaiian or other Pacific Islander.

Symptom status (symptomatic versus asymptomatic) was reported for 616,541 (47%) cases; among these, 22,007 (4%) were asymptomatic. Among 373,883 (28%) cases with data on individual symptoms, 70% noted fever, cough, or shortness of breath; 36% reported muscle aches, and 34% reported headache (Table 2). Overall, 31,191 (8%) persons reported loss of smell or taste.[§§§§] Among patients aged ≥80 years, 60% reported fever, cough, or shortness of breath. No other symptoms were reported by >10% of persons in this age group.

Among 287,320 (22%) cases with data on individual underlying health conditions, those most frequently reported were cardiovascular disease (32%), diabetes (30%), and chronic lung disease (18%) (Table 2); the reported proportions were similar among males and females. The frequency of conditions reported varied by age group: cardiovascular disease was uncommon among those aged ≤39 years but was reported in approximately half of the cases among persons aged ≥70 years. Among 63,896 females aged 15–44 years with known pregnancy status, 6,708 (11%) were reported to be pregnant.

Among the 1,320,488 cases, outcomes for hospitalization, ICU admission, and death were available for 46%, 14%, and 36%, respectively. Overall, 184,673 (14%) patients were hospitalized, including 29,837 (2%) admitted to the ICU; 71,116 (5%) patients died (Table 3). Severe outcomes were more commonly reported for patients with reported underlying conditions. Hospitalizations were six times higher among patients with a reported underlying condition than those without

[§§] According to the Council of State and Territorial Epidemiologists position statement Interim 20-ID-01, a probable case must 1) meet clinical criteria and epidemiologic criteria with no confirmatory laboratory testing performed; 2) have presumptive laboratory evidence, including detection of specific antigen or antibody in a clinical specimen, and meet clinical criteria or epidemiologic criteria; or 3) meet vital records criteria with no confirmatory laboratory testing performed. (https://cdn.ymaws.com/www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdf)

[¶¶] Cases reported from U.S. territories were not included in the analysis because of limited case reporting and lack of available demographically stratified census data. Cases excluded from this analysis include those reported from Guam (116), the Northern Mariana Islands (16), Puerto Rico (one), and the U.S. Virgin Islands (71).

[***] Cases reported as Hispanic were categorized as "Hispanic or Latino persons of any race" regardless of availability of race data.

[†††] The first laboratory-confirmed case of COVID-19 in the United States was confirmed on January 20, 2020, and reported to CDC on January 22, 2020. The upper quartile of the lag between onset date and reporting to CDC was 15 days.

[§§§] From April 15 to May 30, 2020, these aggregate counts include both confirmed and probable cases and deaths. Overall, <1% of cases and 3.1% of deaths were classified as probable.

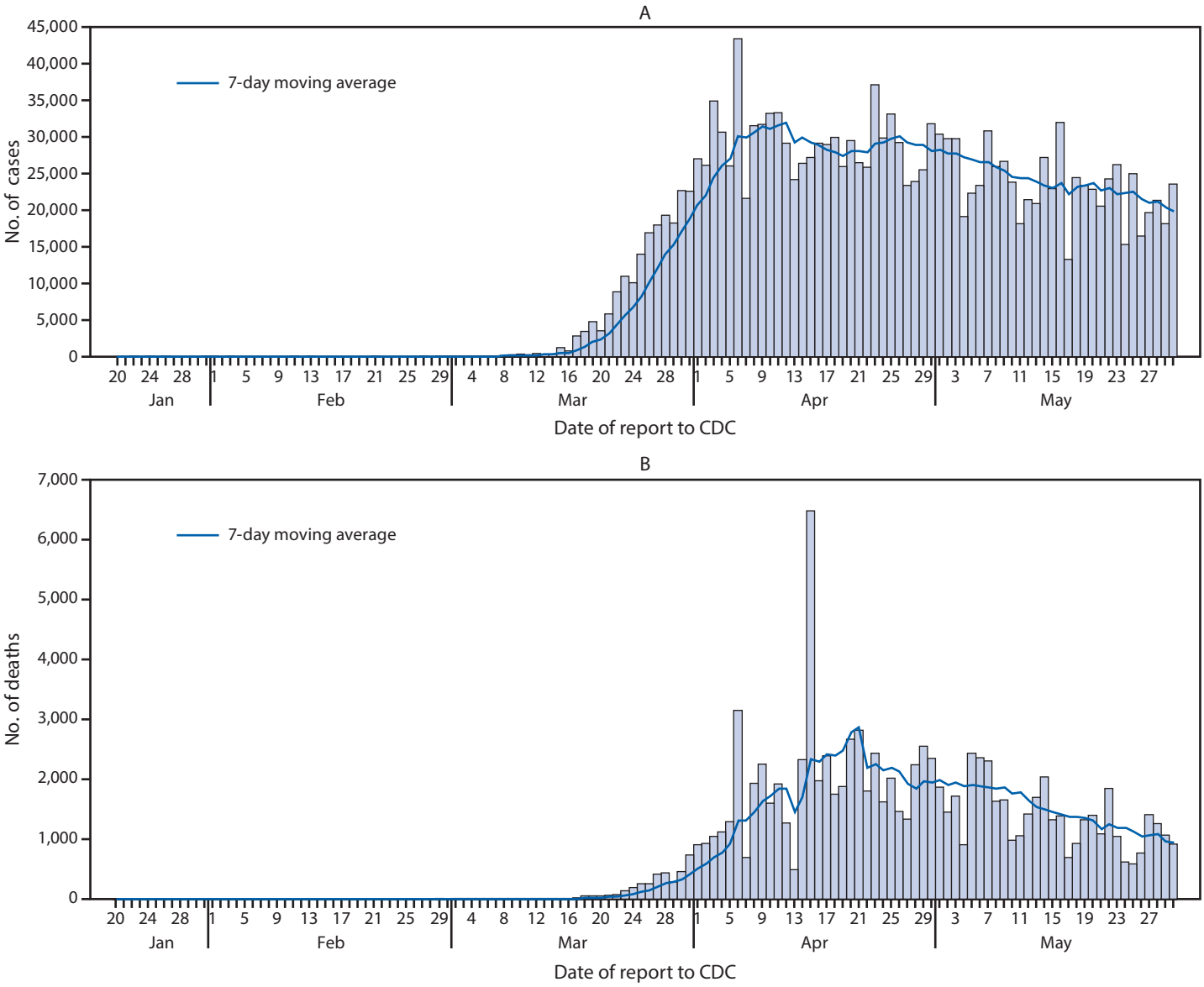
[¶¶¶] The 7-day moving average of new cases and deaths (current day + 6 preceding days / 7) was calculated to smooth expected variations in daily counts.

[****] In some age groups, males had higher incidence, and in some age groups, females had higher incidence.

[††††] Among those aged ≥85 years, incidence was 1,138 per 100,000.

[§§§§] Responses include data from standardized fields supplemented with data from free-text fields; therefore, persons exhibiting this symptom might be underreported.

FIGURE. Daily number of COVID-19 cases*,†,§,¶ (A) and COVID-19–associated deaths (B) reported to CDC — United States, January 22–May 30, 2020**



Abbreviation: COVID-19 = coronavirus disease 2019.

* From April 14, 2020, aggregate case counts reported by CDC included deaths attributable to both confirmed and probable COVID-19 as classified by reporting jurisdictions, using the Council of State and Territorial Epidemiologists position statement Interim-ID-20-01 (https://cdn.ymaws.com/www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdf).

† The upper quartile of the lag between onset date and reporting to CDC was 15 days.

§ The daily number of deaths reported by jurisdictions on April 14 includes 4,141 deaths newly classified as probable.

¶ Overall <1% of cases reported in aggregate to CDC were classified as probable.

** Overall 3.1% of deaths reported in aggregate to CDC were classified as occuring in persons with probable cases.

reported underlying conditions (45.4% versus 7.6%). Deaths were 12 times higher among patients with reported underlying conditions compared with those without reported underlying conditions (19.5% versus 1.6%). The percentages of males who were hospitalized (16%), admitted to the ICU (3%), and who died (6%) were higher than were those for females (12%, 2%, and 5%, respectively). The percentage of ICU admissions was highest among persons with reported underlying conditions aged 60–69 years (11%) and 70–79 years (12%). Death was most commonly reported among persons aged ≥80 years regardless of the presence of underlying conditions (with underlying conditions 50%; without 30%).

TABLE 1. Reported laboratory-confirmed COVID-19 cases and estimated cumulative incidence,* by sex† and age group — United States, January 22–May 30, 2020

	Males		Females		Total	
Age group (yrs)	No. (%)	Cumulative incidence*	No. (%)	Cumulative incidence*	No. (%)	Cumulative incidence*
0–9	10,743 (1.7)	52.5	9,715 (1.4)	49.7	20,458 (1.5)	51.1
10–19	24,302 (3.8)	113.4	24,943 (3.7)	121.4	49,245 (3.7)	117.3
20–29	85,913 (13.3)	370.0	96,556 (14.3)	434.6	182,469 (13.8)	401.6
30–39	108,319 (16.8)	492.8	106,530 (15.8)	490.5	214,849 (16.3)	491.6
40–49	109,745 (17.0)	547.0	109,394 (16.2)	536.2	219,139 (16.6)	541.6
50–59	119,152 (18.4)	568.8	116,622 (17.3)	533.0	235,774 (17.9)	550.5
60–69	93,596 (14.5)	526.9	85,411 (12.7)	434.6	179,007 (13.6)	478.4
70–79	53,194 (8.2)	513.7	52,058 (7.7)	422.7	105,252 (8.0)	464.2
≥80	41,394 (6.4)	842.0	72,901 (10.8)	940.0	114,295 (8.7)	902.0
All ages	**646,358 (100.0)**	**401.1**	**674,130 (100.0)**	**406.0**	**1,320,488 (100.0)**	**403.6**

Abbreviation: COVID-19 = coronavirus disease 2019.
* Per 100,000 population.
† The analytic dataset excludes cases reported through case surveillance that were missing information on sex (n = 19,918) or age (n = 2,379).

TABLE 2. Reported underlying health conditions* and symptoms† among persons with laboratory-confirmed COVID-19, by sex and age group — United States, January 22–May 30, 2020

	No. (%)											
		Sex		Age group (yrs)								
Characteristic	Total	Male	Female	≤9	10–19	20–29	30–39	40–49	50–59	60–69	70–79	≥80
Total population	**1,320,488**	**646,358**	**674,130**	**20,458**	**49,245**	**182,469**	**214,849**	**219,139**	**235,774**	**179,007**	**105,252**	**114,295**
Underlying health condition§												
Known underlying medical condition status*	**287,320 (21.8)**	138,887 (21.5)	148,433 (22.0)	2,896 (14.2)	7,123 (14.5)	27,436 (15.0)	33,483 (15.6)	40,572 (18.5)	54,717 (23.2)	50,125 (28.0)	34,400 (32.7)	36,568 (32.0)
Any cardiovascular disease¶	**92,546 (32.2)**	47,567 (34.2)	44,979 (30.3)	78 (2.7)	164 (2.3)	1,177 (4.3)	3,588 (10.7)	8,198 (20.2)	16,954 (31.0)	21,466 (42.8)	18,763 (54.5)	22,158 (60.6)
Any chronic lung disease	**50,148 (17.5)**	20,930 (15.1)	29,218 (19.7)	363 (12.5)	1,285 (18)	4,537 (16.5)	5,110 (15.3)	6,127 (15.1)	8,722 (15.9)	9,200 (18.4)	7,436 (21.6)	7,368 (20.1)
Renal disease	**21,908 (7.6)**	12,144 (8.7)	9,764 (6.6)	21 (0.7)	34 (0.5)	204 (0.7)	587 (1.8)	1,273 (3.1)	2,789 (5.1)	4,764 (9.5)	5,401 (15.7)	6,835 (18.7)
Diabetes	**86,737 (30.2)**	45,089 (32.5)	41,648 (28.1)	12 (0.4)	225 (3.2)	1,409 (5.1)	4,106 (12.3)	9,636 (23.8)	19,589 (35.8)	22,314 (44.5)	16,594 (48.2)	12,852 (35.1)
Liver disease	**3,953 (1.4)**	2,439 (1.8)	1,514 (1.0)	5 (0.2)	19 (0.3)	132 (0.5)	390 (1.2)	573 (1.4)	878 (1.6)	1,074 (2.1)	583 (1.7)	299 (0.8)
Immunocompromised	**15,265 (5.3)**	7,345 (5.3)	7,920 (5.3)	61 (2.1)	146 (2.0)	646 (2.4)	1,253 (3.7)	2,005 (4.9)	3,190 (5.8)	3,421 (6.8)	2,486 (7.2)	2,057 (5.6)
Neurologic/ Neurodevelopmental disability	**13,665 (4.8)**	6,193 (4.5)	7,472 (5.0)	41 (1.4)	113 (1.6)	395 (1.4)	533 (1.6)	734 (1.8)	1,338 (2.4)	2,006 (4.0)	2,759 (8.0)	5,746 (15.7)
Symptom§												
Known symptom status†	**373,883 (28.3)**	178,223 (27.6)	195,660 (29.0)	5,188 (25.4)	12,689 (25.8)	51,464 (28.2)	59,951 (27.9)	62,643 (28.6)	70,040 (29.7)	52,178 (29.1)	28,583 (27.2)	31,147 (27.3)
Fever, cough, or shortness of breath	**260,706 (69.7)**	125,768 (70.6)	134,938 (69.0)	3,278 (63.2)	7,584 (59.8)	35,072 (68.1)	42,016 (70.1)	45,361 (72.4)	51,283 (73.2)	37,701 (72.3)	19,583 (68.5)	18,828 (60.4)
Fever††	**161,071 (43.1)**	80,578 (45.2)	80,493 (41.1)	2,404 (46.3)	4,443 (35.0)	20,381 (39.6)	25,887 (43.2)	28,407 (45.3)	32,375 (46.2)	23,591 (45.2)	12,190 (42.6)	11,393 (36.6)
Cough	**187,953 (50.3)**	89,178 (50.0)	98,775 (50.5)	1,912 (36.9)	5,257 (41.4)	26,284 (51.1)	31,313 (52.2)	34,031 (54.3)	38,305 (54.7)	27,150 (52.0)	12,837 (44.9)	10,864 (34.9)
Shortness of breath	**106,387 (28.5)**	49,834 (28.0)	56,553 (28.9)	339 (6.5)	2,070 (16.3)	13,649 (26.5)	16,851 (28.1)	18,978 (30.3)	21,327 (30.4)	16,018 (30.7)	8,971 (31.4)	8,184 (26.3)
Myalgia	**135,026 (36.1)**	61,922 (34.7)	73,104 (37.4)	537 (10.4)	3,737 (29.5)	21,153 (41.1)	26,464 (44.1)	28,064 (44.8)	28,594 (40.8)	17,360 (33.3)	6,015 (21.0)	3,102 (10.0)
Runny nose	**22,710 (6.1)**	9,900 (5.6)	12,810 (6.5)	354 (6.8)	1,025 (8.1)	4,591 (8.9)	4,406 (7.3)	4,141 (6.6)	4,100 (5.9)	2,671 (5.1)	923 (3.2)	499 (1.6)
Sore throat	**74,840 (20.0)**	31,244 (17.5)	43,596 (22.3)	664 (12.8)	3,628 (28.6)	14,493 (28.2)	14,855 (24.8)	14,490 (23.1)	13,930 (19.9)	8,192 (15.7)	2,867 (10.0)	1,721 (5.5)
Headache	**128,560 (34.4)**	54,721 (30.7)	73,839 (37.7)	785 (15.1)	5,315 (41.9)	23,723 (46.1)	26,142 (43.6)	26,245 (41.9)	26,057 (37.2)	14,735 (28.2)	4,163 (14.6)	1,395 (4.5)
Nausea/Vomiting	**42,813 (11.5)**	16,549 (9.3)	26,264 (13.4)	506 (9.8)	1,314 (10.4)	6,648 (12.9)	7,661 (12.8)	8,091 (12.9)	8,737 (12.5)	5,953 (11.4)	2,380 (8.3)	1,523 (4.9)
Abdominal pain	**28,443 (7.6)**	11,553 (6.5)	16,890 (8.6)	349 (6.7)	978 (7.7)	4,211 (8.2)	5,150 (8.6)	5,531 (8.8)	6,134 (8.8)	3,809 (7.3)	1,449 (5.1)	832 (2.7)
Diarrhea	**72,039 (19.3)**	32,093 (18.0)	39,946 (20.4)	704 (13.6)	1,712 (13.5)	9,867 (19.2)	12,769 (21.3)	13,958 (22.3)	15,536 (22.2)	10,349 (19.8)	4,402 (15.4)	2,742 (8.8)
Loss of smell or taste	**31,191 (8.3)**	12,717 (7.1)	18,474 (9.4)	67 (1.3)	1,257 (9.9)	6,828 (13.3)	6,907 (11.5)	6,361 (10.2)	5,828 (8.3)	2,930 (5.6)	775 (2.7)	238 (0.8)

Abbreviation: COVID-19 = coronavirus disease 2019.
* Status of underlying health conditions known for 287,320 persons. Status was classified as "known" if any of the following conditions were reported as present or absent: diabetes mellitus, cardiovascular disease (including hypertension), severe obesity (body mass index ≥40 kg/m^2), chronic renal disease, chronic liver disease, chronic lung disease, immunocompromising condition, autoimmune condition, neurologic condition (including neurodevelopmental, intellectual, physical, visual, or hearing impairment), psychologic/psychiatric condition, and other underlying medical condition not otherwise specified.
† Symptom status was known for 373,883 persons. Status was classified as "known" if any of the following symptoms were reported as present or absent: fever (measured >100.4°F [38°C] or subjective), cough, shortness of breath, wheezing, difficulty breathing, chills, rigors, myalgia, rhinorrhea, sore throat, chest pain, nausea or vomiting, abdominal pain, headache, fatigue, diarrhea (≥3 loose stools in a 24-hour period), or other symptom not otherwise specified on the form.
§ Responses include data from standardized fields supplemented with data from free-text fields. Information for persons with loss of smell or taste was exclusively extracted from a free-text field; therefore, persons exhibiting this symptom were likely underreported.
¶ Includes persons with reported hypertension.
** Includes all persons with at least one of these symptoms reported.
†† Persons were considered to have a fever if information on either measured or subjective fever variables if "yes" was reported for either variable.

TABLE 3. Reported hospitalizations,*,† intensive care unit (ICU) admissions,§ and deaths¶ among laboratory-confirmed COVID-19 patients with and without reported underlying health conditions, by sex and age — United States, January 22–May 30, 2020**

	Outcome, no./total no. (%)††								
	Reported hospitalizations*,† (including ICU)			Reported ICU admission§			Reported deaths¶		
Characteristic (no.)	Among all patients	Among patients with reported underlying health conditions	Among patients with no reported underlying health conditions	Among all patients	Among patients with reported underlying health conditions	Among patients with no reported underlying health conditions	Among all patients	Among patients with reported underlying health conditions	Among patients with no reported underlying health conditions
Sex									
Male (646,358)	101,133/646,358 (15.6)	49,503/96,839 (51.1)	3,596/42,048 (8.6)	18,394/646,358 (2.8)	10,302/96,839 (10.6)	864/42,048 (2.1)	38,773/646,358 (6.0)	21,667/96,839 (22.4)	724/42,048 (1.7)
Female (674,130)	83,540/674,130 (12.4)	40,698/102,040 (39.9)	3,087/46,393 (6.7)	11,443/674,130 (1.7)	6,672/102,040 (6.5)	479/46,393 (1.0)	32,343/674,130 (4.8)	17,145/102,040 (16.8)	707/46,393 (1.5)
Age group (yrs)									
≤9 (20,458)	848/20,458 (4.1)	138/619 (22.3)	84/2,277 (3.7)	141/20,458 (0.7)	31/619 (5.0)	16/2,277 (0.7)	13/20,458 (0.1)	4/619 (0.6)	2/2,277 (0.1)
10–19 (49,245)	1,234/49,245 (2.5)	309/2,076 (14.9)	115/5,047 (2.3)	216/49,245 (0.4)	72/2,076 (3.5)	17/5,047 (0.3)	33/49,245 (0.1)	16/2,076 (0.8)	4/5,047 (0.1)
20–29 (182,469)	6,704/182,469 (3.7)	1,559/8,906 (17.5)	498/18,530 (2.7)	864/182,469 (0.5)	300/8,906 (3.4)	56/18,530 (0.3)	273/182,469 (0.1)	122/8,906 (1.4)	24/18,530 (0.1)
30–39 (214,849)	12,570/214,849 (5.9)	3,596/14,854 (24.2)	828/18,629 (4.4)	1,879/214,849 (0.9)	787/14,854 (5.3)	135/18,629 (0.7)	852/214,849 (0.4)	411/14,854 (2.8)	21/18,629 (0.1)
40–49 (219,139)	19,318/219,139 (8.8)	7,151/24,161 (29.6)	1,057/16,411 (6.4)	3,316/219,139 (1.5)	1,540/24,161 (6.4)	208/16,411 (1.3)	2,083/219,139 (1.0)	1,077/24,161 (4.5)	58/16,411 (0.4)
50–59 (235,774)	31,588/235,774 (13.4)	14,639/40,297 (36.3)	1,380/14,420 (9.6)	5,986/235,774 (2.5)	3,335/40,297 (8.3)	296/14,420 (2.1)	5,639/235,774 (2.4)	3,158/40,297 (7.8)	131/14,420 (0.9)
60–69 (179,007)	39,422/179,007 (22.0)	21,064/42,206 (49.9)	1,216/7,919 (15.4)	7,403/179,007 (4.1)	4,588/42,206 (10.9)	291/7,919 (3.7)	11,947/179,007 (6.7)	7,050/42,206 (16.7)	187/7,919 (2.4)
70–79 (105,252)	35,844/105,252 (34.1)	20,451/31,601 (64.7)	780/2,799 (27.9)	5,939/105,252 (5.6)	3,771/31,601 (11.9)	199/2,799 (7.1)	17,510/105,252 (16.6)	10,008/31,601 (31.7)	286/2,799 (10.2)
≥80 (114,295)	37,145/114,295 (32.5)	21,294/34,159 (62.3)	725/2,409 (30.1)	4,093/114,295 (3.6)	2,550/34,159 (7.5)	125/2,409 (5.2)	32,766/114,295 (28.7)	16,966/34,159 (49.7)	718/2,409 (29.8)
Total (1,320,488)	**184,673/1,320,488 (14.0)**	**90,201/198,879 (45.4)**	**6,683/88,441 (7.6)**	**29,837/1,320,488 (2.3)**	**16,974/198,879 (8.5)**	**1,343/88,441 (1.5)**	**71,116/1,320,488 (5.4)**	**38,812/198,879 (19.5)**	**1,431/88,441 (1.6)**

Abbreviation: COVID-19 = coronavirus disease 2019.

* Hospitalization status was known for 600,860 (46%). Among 184,673 hospitalized patients, the presence of underlying health conditions was known for 96,884 (53%).

† Includes reported ICU admissions.

§ ICU admission status was known for 186,563 (14%) patients among the total case population, representing 34% of hospitalized patients. Among 29,837 patients admitted to the ICU, the status of underlying health conditions was known for 18,317 (61%).

¶ Death outcomes were known for 480,565 (36%) patients. Among 71,116 reported deaths through case surveillance, the status of underlying health conditions was known for 40,243 (57%) patients.

** Status of underlying health conditions was known for 287,320 (22%) patients. Status was classified as "known" if any of the following conditions were noted as present or absent: diabetes mellitus, cardiovascular disease including hypertension, severe obesity body mass index ≥40 kg/m^2, chronic renal disease, chronic liver disease, chronic lung disease, any immunocompromising condition, any autoimmune condition, any neurologic condition including neurodevelopmental, intellectual, physical, visual, or hearing impairment, any psychologic/psychiatric condition, and any other underlying medical condition not otherwise specified.

†† Outcomes were calculated as the proportion of persons reported to be hospitalized, admitted to an ICU, or who died among total in the demographic group. Outcome underreporting could result from outcomes that occurred but were not reported through national case surveillance or through clinical progression to severe outcomes that occurred after time of report.

Discussion

As of May 30, a total of 1,761,503 aggregate U.S. cases of COVID-19 and 103,700 associated deaths were reported to CDC. Although average daily reported cases and deaths are declining, 7-day moving averages of daily incidence of COVID-19 cases indicate ongoing community transmission.¶¶¶¶

The COVID-19 case data summarized here are essential statistics for the pandemic response and rely on information systems developed at the local, state, and federal level over decades for communicable disease surveillance that were rapidly adapted to meet an enormous, new public health threat. CDC aggregate counts are consistent with those presented through the Johns Hopkins University (JHU) Coronavirus Resource Center, which reported a cumulative total of 1,770,165 U.S. cases and 103,776 U.S. deaths on May 30, 2020.***** Differences in aggregate counts between CDC and JHU might be attributable to differences in reporting practices to CDC and jurisdictional websites accessed by JHU.

Reported cumulative incidence in the case surveillance population among persons aged ≥20 years is notably higher than that among younger persons. The lower incidence in persons aged ≤19 years could be attributable to undiagnosed milder or asymptomatic illnesses among this age group that

¶¶¶¶ Community transmission is defined by states and reflects varying conditions at the local and state levels.

***** COVID-19 Dashboard by the Center for Systems Science and Engineering at Johns Hopkins University is a publicly available data tracker that extracts data from state, territorial, and local public health websites (https://coronavirus.jhu.edu/us-map). Data are archived in GitHub (https://github.com/CSSEGISandData/COVID-19/blob/master/csse_covid_19_data/csse_covid_19_daily_reports_us/05-30-2020.csv).

were not reported. Incidence in persons aged ≥80 years was nearly double that in persons aged 70–79 years.

Among cases with known race and ethnicity, 33% of persons were Hispanic, 22% were black, and 1.3% were AI/AN. These findings suggest that persons in these groups, who account for 18%, 13%, and 0.7% of the U.S. population, respectively, are disproportionately affected by the COVID-19 pandemic. The proportion of missing race and ethnicity data limits the conclusions that can be drawn from descriptive analyses; however, these findings are consistent with an analysis of COVID-19–Associated Hospitalization Surveillance Network (COVID-NET)[†††††] data that found higher proportions of black and Hispanic persons among hospitalized COVID-19 patients than were in the overall population (*4*). The completeness of race and ethnicity variables in case surveillance has increased from 20% to >40% from April 2 to June 2. Although reporting of race and ethnicity continues to improve, more complete data might be available in aggregate on jurisdictional websites or through sources like the COVID Tracking Project's COVID Racial Data Tracker.[§§§§§]

The data in this report show that the prevalence of reported symptoms varied by age group but was similar among males and females. Fewer than 5% of persons were reported to be asymptomatic when symptom data were submitted. Persons without symptoms might be less likely to be tested for COVID-19 because initial guidance recommended testing of only symptomatic persons and was hospital-based. Guidance on testing has evolved throughout the response.[¶¶¶¶¶] Whereas incidence among males and females was similar overall, severe outcomes were more commonly reported among males. Prevalence of reported severe outcomes increased with age; the percentages of hospitalizations, ICU admissions, and deaths were highest among persons aged ≥70 years, regardless of underlying conditions, and lowest among those aged ≤19 years. Hospitalizations were six times higher and deaths 12 times higher among those with reported underlying conditions compared with those with none reported. These findings are consistent with previous reports that found that severe outcomes increased with age and underlying condition, and males were hospitalized at a higher rate than were females (*2*,*4*,*5*).

The findings in this report are subject to at least three limitations. First, case surveillance data represent a subset of the total cases of COVID-19 in the United States; not every case in the community is captured through testing and information collected might be limited if persons are unavailable or unwilling to participate in case investigations or if medical records are unavailable for data extraction. Reported cumulative incidence, although comparable across age and sex groups within the case surveillance population, are underestimates of the U.S. cumulative incidence of COVID-19. Second, reported frequencies of individual symptoms and underlying health conditions presented from case surveillance likely underestimate the true prevalence because of missing data. Finally, asymptomatic cases are not captured well in case surveillance. Asymptomatic persons are unlikely to seek testing unless they are identified through active screening (e.g., contact tracing), and, because of limitations in testing capacity and in accordance with guidance, investigation of symptomatic persons is prioritized. Increased identification and reporting of asymptomatic cases could affect patterns described in this report.

Similar to earlier reports on COVID-19 case surveillance, severe outcomes were more commonly reported among persons who were older and those with underlying health conditions (*1*). Findings in this report align with demographic and severe outcome trends identified through COVID-NET (*4*). Findings from case surveillance are evaluated along with enhanced surveillance data and serologic survey results to provide a comprehensive picture of COVID-19 trends, and differences in proportion of cases by racial and ethnic groups should continue to be examined in enhanced surveillance to better understand populations at highest risk.

Since the U.S. COVID-19 response began in January, CDC has built on existing surveillance capacity to monitor the impact of illness nationally. Collection of detailed case

Summary

What is already known about this topic?

Surveillance data reported to CDC through April 2020 indicated that COVID-19 leads to severe outcomes in older adults and those with underlying health conditions.

What is added by this report?

As of May 30, 2020, among COVID-19 cases, the most common underlying health conditions were cardiovascular disease (32%), diabetes (30%), and chronic lung disease (18%). Hospitalizations were six times higher and deaths 12 times higher among those with reported underlying conditions compared with those with none reported.

What are the implications for public health practice?

Surveillance at all levels of government, and its continued modernization, is critical for monitoring COVID-19 trends and identifying groups at risk for infection and severe outcomes. These findings highlight the continued need for community mitigation strategies, especially for vulnerable populations, to slow COVID-19 transmission.

[†††††] COVID-Net is a population-based surveillance system that collects data on laboratory-confirmed COVID-19–associated hospitalizations (https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covid-net/purpose-methods.html).
[§§§§§] The COVID Tracking Project is *The Atlantic's* volunteer organization to collect and publish U.S. COVID-19 data (https://covidtracking.com/race/dashboard).
[¶¶¶¶¶] https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html.

data is a resource-intensive public health activity, regardless of disease incidence. The high incidence of COVID-19 has highlighted limitations of traditional public health case surveillance approaches to provide real-time intelligence and supports the need for continued innovation and modernization. Despite limitations, national case surveillance of COVID-19 serves a critical role in the U.S. COVID-19 response: these data demonstrate that the COVID-19 pandemic is an ongoing public health crisis in the United States that continues to affect all populations and result in severe outcomes including death. National case surveillance findings provide important information for targeted enhanced surveillance efforts and development of interventions critical to the U.S. COVID-19 response.

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